Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:30 a.m. on October 6, 2005, and 8:00 a.m. on October 7, 2005
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members
Tim B. Hunter, M.D., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Ronnie R. Cox, Ph.D.
Robert P. Goldfarb, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin, Sr., M.D.

THURSDAY, October 6, 2005

CALL TO ORDER
Tim B. Hunter called the meeting to order at 9:30 a.m.

ROLL CALL
The following Board Members were present: Tim B. Hunter, M.D., M.D., Douglas D. Lee, M.D., Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D., The following Board Member was not present: Sharon B. Megdal, Ph.D.

William R. Martin, III, M.D. arrived at the meeting at 9:35 a.m.

CALL TO THE PUBLIC
Statements issued during the Call to the Public appear beneath the case referenced.

Executive Director's Report
Timothy Miller, Executive Director, also spoke on the Board's positive progress on the backlog of cases. Mr. Miller stated there is no longer a bottleneck of cases and everything is going through the process smoothly. Mr. Miller said the agency's goal is to reduce the number of cases to a reasonable case load. Mr. Miller stated the reduction in the backlog demonstrates the quality of the Staff in keeping up with the cases coming to the Board while at the same time making headway. Mr. Miller said work is continually being made to enhance to the process in order to be able to move more quickly through the backlog. Mr. Miller stated the auditors are usually satisfied if the agency does not have a growing case load.

Patrick N. Connell, M.D. noted that some cases are not moved through the process as quickly as others. Mr. Miller stated that as the cases that pose an imminent threat have been triaged, likewise the cases that have been in the system the longest can be triaged as well.

Licensing Fee Increase Memo
Suzanne Grabe Licensing Office Manager, asked the Board to clarify an October 2001 vote on Licensing fees. The October 2001 Minutes reflect the Board approved the fees as presented, however, the Board's Rules were never updated and some of the new fees were never implemented. Ms. Grabe asked the Board to review the fees as listed and vote on whether they wish to reaffirm their 2001 vote. If the Board votes to approve the fees a Substantive Policy Statement will be drafted and will be in effect until the Rules are updated.

The following fee increases were approved in October 2001 and were implemented by Staff:

- Initial Licensing Fee- $450.00 to $500.00
- License Renewal Fee- $450.00 to $500.00
- Non-sufficient funds fee- $25.00

The following fee increases were also approved according to the minutes, but not implemented by Staff:

- Reactivation of inactive license fee- $50.00
- Processing of deficient license renewal -$25.00
- Locum tenens registration-$200.00 to $350.00
- Drug Dispensing Renewal-$100.00 to $150.00
- Annual Teaching license- $225.00 to $250.00
- Post Graduate Training Permit- $25.00 to $50.00
- Verification of Licensure- $5.00 to $10.00

MOTION: Robert P. Goldfarb, M.D. moved to approved the fees as presented.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Licensing Application Refund Policy

Christine Cassetta, Board Legal Counsel asked the Board to consider reversing the policy for issuing application fee refund as this was a point that was brought up by the auditors.

MOTION: Ram R. Krishna, M.D. moved to amend its policy on fee refunds to exclude refunds of the application fee.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Litigation Report

Timothy C. Miller, J.D., Executive Director informed the Board their approval was required for Legislation proposed for the next Legislative session.

Mr. Miller summed up the five pieces of Proposed Legislation:

1) Board authority to issue non-disciplinary orders requiring a physician complete continuing medical education (CME).
2) Board authority to reject any AMA approved or accredited school if the Board determines the curriculum to be insufficient to provide the required education.
3) Amending the Office Based Surgery definition to include inhalation anesthesia and major conductive nerve block.
4) Board authority to require a physician to undergo an evaluation or assessment not part of a defined program at the physician's expense.
5) Clarify appeals of Executive Director actions.

Ram R. Krishna, M.D. commented on Proposal Two and noted that a large number of physicians come from abroad. Dr. Krishna also noted the state Medical Boards have asked the Federation of State Medical Boards (FSMB) to look into the issue of foreign medical schools possibly not providing sufficient education. Dr. Krishna said it may be good to wait until the FSMB completes their research in order to save the Board's resources.

Tim B. Hunter, M.D. suggested that part of the legislation be the school must cover the cost of a representative from the Board to travel out of country to evaluate the school's curriculum.

MOTION: Robert P. Goldfarb, M.D. moved to accept the Executive Director's suggestion for proposed legislation.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Chair's Report

Tim B. Hunter, M.D. gave an overview of the Board's off-site meeting, noting it was a good meeting. Dr. Hunter stated the Board was able to review the Staff's investigative process and feels a great system is in place. Dr. Hunter stated he is very happy at the direction in which the agency is going and praised the Staff. Dr. Hunter also expressed his appreciation for the Executive Director, the Board's Legal Counsel, Board Litigators, and the Board's Medical Consultants.

Dr. Hunter noted that the Arizona Medical Board is a high profile agency and that both physicians and public will be upset at various times. Nevertheless, Dr. Hunter said he has a high regard for his fellow Board Members and knows they work very hard. Dr. Hunter acknowledged the Staff is working to bring the timeframe for processing complaints down and is addressing the complaint backlog.

Robert P. Goldfarb, M.D. also praised the Board's Staff stating the previous ten to eleven months have been a rebuilding process that he knows is never smooth or easy. He said that a period less than one year is too short a timeframe to judge the agency's rebuilding results. He said he was favorably impressed with the agency's new procedures but that it will take time to implement each process. However, Dr. Goldfarb said he said he was encouraged with the Board's progress. Dr. Goldfarb stated people have made accusations and left the agency, but that is not unusual when a new administration comes. He felt the Staff who were used to doing things the old way have left. Dr. Goldfarb said it is not a

secret that physicians feel the Board is too strict while complainant's feel the Board is too lenient. However, he said he knows the Staff and the Board have the same goal, to protect the public, and he encouraged the Staff to not give up the focus.

Ram R. Krishna, M.D. stated he had been with the Board for many years and noted the investigative process has now evolved into a superb procedure. Dr. Krishna noted the Executive Director deserves to be given leeway as he implements and works through new procedures. Dr. Krishna also said he is encouraged at the unity he has noticed among Staff. Dr. Krishna stated the Arizona Medical Board is a difficult Board to be on, but that it is a quality Board and gives the Staff credit for that.

Ronnie R. Cox, Ph.D., encouraged and complimented the Board's Staff by sharing five axioms for mission success that he used while in the military: 1) keep your wits; 2) there will always be a lot of change; 3) these changes will create a fast moving environment; 4) a fast moving environment will create a degree of discomfort; and 5) stay mission focused, mission oriented and know what you are supposed to do and of course, keep your bearing. He stated those axioms were present in the agency and congratulated the Staff for a job well done.

Legal Advisor's Report

Christine Cassetta, Legal Counsel commented on the Superior Court's decision in the judicial review action of Ritland vs. Arizona Medical Board. Ms. Cassetta stated one of the Court's determinations was that the Administrative Law Judge makes the credibility determination and the Board is bound by that determination. The Court upheld the Arizona Medical Board's decision in total, but since it is not known whether the decision will be appealed, she did not provide the decision to the Board. Ms. Cassetta noted she will provide the Board with the decision if there is no appeal.

Definition of Self Report for Board Rehabilitation Programs

Mr. Miller asked the Board to decide whether after the Board receives a DUI report there can still be grounds for a physician self-report and enter the confidential rehabilitation program or whether it is too late at that point.

Dr. Connell mentioned the Staff presented four possible categories for a DUI report that he would be willing to accept. The four proposed categories are:

1) A late DUI report or no report, with no finding of addiction – advisory letter for failure to timely report the DUI
2) A late DUI report or no report, with finding of addiction and physician admission– advisory letter for late report, confidential rehabilitation agreement.
3) A DUI with a timely report and no addiction – case would be dismissed.
4) A DUI with a timely report with admission of addiction – confidential rehabilitation agreement.

Dr. Connell stated the Board's previous policy was too strict and discouraged people from seeking help from the Board's Monitored Aftercare Program and this increases the danger to the public. He noted that if more physicians are willing to participate in the confidential program it would benefit the public.

MOTION: Patrick N. Connell, M.D. moved to adopt the Staff's four part method of disposition and to rescind the 2003 decision of the Board that a DUI precluded a physician from being able to self-report.
SECONDED: William R. Martin, III, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Approval of Minutes

The Board mentioned they had received a request from Dr. Goel's attorney to make a change to the minutes from the Summary Action meeting to reflect facts that were subsequently developed that may establish Dr. Goel was not alone with a female patient. Christine Cassetta, Legal Counsel, noted the Board has received requests in the past to change the minutes based on occurrences after the meeting and the Board has rejected these requests because the minutes as written reflect what was known to the Board at the time and are not subsequently changed.

Tim B. Hunter, M.D. said the Board has elected never to change the minutes unless there has been an error or a correction and he believes the minutes should always reflect what actually took place and was said during the meeting.

MOTION: Ram R. Krishna, M.D. moved to approve the minutes from the August 10-11, 2005 meeting, including Executive Session minutes and the August 11, 2005 Special Meeting minutes, the August 22, 2005 Summary Action Meeting minutes and the August 30, 2005 Summary Action Meeting minutes.
SECONDED: Dona Pardo, R.N., Ph.D.
VOTE: 9 yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-1362B	K.C.	WILLIAM G. SCHWARK, M.D.	11875	Dismissed

Douglas D. Lee, M.D. pulled the case for discussion. Dr. Lee said he feels an Advisory Letter is unwarranted, because the physician followed the standard of care and although the outcome was poor, Dr. Lee said it was difficult to determine if the outcome may have been poor from the beginning of the patient's arrest.

MOTION: Douglas D. Lee, M.D. moved to find there was no unprofessional conduct and that the case be dismissed.
SECONDED: Patrick N. Connell, M.D.

Paul M. Petelin, M.D. commented Dr. Schwark was not the anesthesiologist of record for the initial surgery and was not involved with the patient until the time of the arrest. Dr. Petelin spoke in favor of the motion.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0146A	S.O.	SCOTT C. FORRER, M.D.	19296	Advisory Letter for failure to properly examine and evaluate a patient with headaches and seizure history.

Robert P. Goldfarb, M.D. recused himself from the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-03-1308A	R.S.	DEIDRE J. SOLBERG-DANIELS, M.D.	16168	Dismissed

Patrick N. Connell, M.D. pulled the case for discussion. He stated the inadvertent transfer of records was apparently a clerical error. The records were sent to a patient with the same last name, but with a different address. Dr. Connell said it was easy to see how this error could have occurred.

MOTION: Patrick N. Connell, M.D. moved to dismiss the complaint.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-04-0318A	T.R.	CHARLES A. ATKINSON, M.D.	26810	Invite Physician for a Formal Interview

T.R. was present and spoke at the Call to the Public. T.R. stated she was a victim of a devastating breast surgery. She stated the physical pain from the damage of the surgery has placed limits on every aspect of her life including normal daily activities. T.R. stated she has had to regain range of motion and has had to re-learn balance when bending over. T.R. stated she has had phantom pain and has had to endure hours of therapy and counseling sessions because of the emotional strain of her limitations and the severe violation to her body. T.R. stated that approximately three and one half years after the procedure, a plastic surgeon was able to reconstruct her breasts for pain relief and make correction to the disfigurement by performing a seven and a half hour surgery. She stated the plastic surgeon removed masses caused by tissue damage and discovered damaged nerves. The corrective surgery also helped to ease the severe muscle spasms that would leave her neck immobile and ears numb. She stated Dr. Atkinson was foolish for performing a surgery that should have been referred to a plastic surgeon.

Robert P. Goldfarb, M.D. asked William Wolf, M.D. to give his comments on the reduction mammoplasty. Dr. Wolf stated the Outside Medical Consultant felt the physician did not fall below the standard of care and the complication was relatively minor.

Paul M. Petelin, Sr., M.D. said he did not notice a significant cosmetic deformity from the photographs presented in the case, but does have a problem with Dr. Atkinson performing reduction mammoplasties because it is outside the scope of training for a general surgeon to do that type of procedure. He also commented that plastic surgeons have two extra years of training above a general surgeon.

Tim B. Hunter, M.D. stated the Outside Medical Consultant noted that participating in 27 operations does not constitute adequate training. Dr. Hunter stated he would like to bring the physician in for a formal interview.

MOTION: Robert P. Goldfarb, M.D. moved to invite the physician before the Board for a formal interview.
SECONDED: Ronnie R. Cox, Ph.D.

Patrick N. Connell, M.D. verified with Christine Cassetta, Board Legal Counsel, that a general surgeon doing this type of procedure must practice to level of a plastic surgeon.

VOTE: 10-yay, 1-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-04-0862A	C.B.	ALBERT Q. TEJADA, M.D.	17710	Advisory Letter for inadequate surgical preparation. The violation is a minor or technical violation that is not of sufficient merit to warrant discipline.
6.	MD-03-0450A	AMB	RANDI GERMAINE, M.D.	21309	Advisory Letter for prescribing to a family member. The violation is a minor or technical violation that is not of sufficient merit to warrant discipline.

Ronnie R. Cox, Ph.D. pulled the case for discussion.

Tim B. Hunter, M.D. asked why the recommendation from Board's Staff was for an Advisory Letter and not disciplinary action. Christine Cassetta, Board Legal Counsel noted the Board had pulled this case and the next case and asked her to research the Board's actions in the past when dealing with physicians prescribing controlled substances to immediate family members. Ms. Cassetta noted the Board had only disciplined a physician for such prescribing when the prescriptions were written solely for diversion to the physician. In each of these two cases there was no diversion and the physicians adequately explained their errors.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0158A	R.S.	MARTIN H. LEHMAN, M.D.	18680	Advisory Letter for prescribing a controlled substance to his spouse. The violation is a minor or technical violation that is not of sufficient merit to warrant discipline.
8.	MD-04-0589A	AMB	JONATHAN M. LEVY	8720	Advisory Letter for inadequate performance of an angiogram. The violation is a minor or technical violation that is not of sufficient merit to warrant discipline.

Tim B. Hunter, M.D. and Lorraine Mackstaller, M.D. recused themselves from the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-04-1276A	J.M.	HERBERT W. WONG	15422	Advisory Letter for poor documentation supporting the diagnosis and treatment.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-04-1262A	R.C.	MARK B. MECIKALSKI, M.D.	13945	Dismiss

Robert P. Goldfarb, M.D. pulled this case for discussion.

Lorraine Mackstaller, M.D. stated it is not uncommon to give a beta block and calcium block together. She further commented that when the patient is having symptoms both on and off the medication it is hard to blame the medication.

MOTION: Lorraine Mackstaller, M.D. moved to Dismiss the matter.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-05-0037A	L.B.	FRANCISCO N. RODRIGUEZ, M.D.	21376	Dismiss

L.B. was present and spoke at the Call to the Public. L.B. alleged his small infection became large because the physician failed to act in a timely manner resulting in hospitalization. L.B. stated he had monetary loss and asked the Board to order restitution in the amount of one million dollars.

Dr. Rodriguez was present and spoke during the Call to the Public. Dr. Rodriguez went over the risks with the patient and gave him with a pamphlet to further explain the risks of obesity and infection involved. Dr. Rodriguez stated the patient should also be accountable to learn about the procedure.

Paul M. Petelin, M.D. pulled the case for discussion. He stated he did not believe there would have been an alternative form of treatment for this patient because anything other than surgery for the recurrent hernia would have been below the Standard of Care. Dr. Petelin said the risks of not performing the surgery are greater than performing the surgery and that it is not an elective procedure in that sense. Dr. Petelin said it is only an elective procedure in that you can plan for it. Dr. Petelin said the booklet Dr. Rodriguez gives out is excellent in informing patients of the procedure.

MOTION: Paul M. Petelin, M.D. moved to Dismiss the case.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-04-1374B	D.F.	LUIS A. MUNOZ, M.D.	9794	Advisory Letter for failing to timely diagnose and treat an infected popliteal bypass graft that resulted in prolonged and unnecessary wound care.

Dr. Munoz was present with counsel and spoke during the call to the public. Dr. Munoz spoke in relation to one issue which was the antibiotic used on the patient. Dr. Munoz stated the patient had an infection with drainage, but had no fever. Dr. Munoz stated the standard of care is not to do antibiotic treatment at this time. He stated the patient's immune system was compromised due to his lifestyle. Dr. Munoz stated he treated the patient with Ciprofloxacin. Since the patient did not respond well to the medication, another medication was started.

Patrick N. Connell, M.D. pulled the case for discussion.

Robert P. Goldfarb, M.D. stated the Vancomycin medication had been stopped after treatment for 4-6 weeks. The physician discovered the patient still had the infection and placed the patient on Ciprofloxacin. Dr. Goldfarb said Ciprofloxacin is not the appropriate treatment for methacillin resistant staphylococcus aureus (MRSA).

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter for failing to timely diagnose and treat an infected popliteal bypass graft that resulted in prolonged and unnecessary wound care.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Douglas D. Lee, M.D. moved to Issue Advisory Letters for items 2,5,6,7,8, and 9.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

APPEAL OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0236A	G.K.	WILLIAM J. KENNELL, M.D.	5350	Uphold the Executive Director's Dismissal.

Complainant G.K. was present and spoke during the Call to the Public. She stated as a nurse she has been involved in patient care. She stated her son is a physician and the Arizona Medical Board had revoked her son's license based on the recommendation of Dr. Kennell, a former Board medical consultant. The complainant alleged Dr. Kennell was not able to testify to the standard of care because he was not current on his CME.

Paul M. Petelin, Sr., M.D. asked Christine Cassetta, Board Legal Counsel, about the rules governing Board Medical Consultant's obtaining continuing medical education (CME) credits. Ms. Cassetta stated complainant G.K. misinterpreted the applicable Board Rule giving physician's credit for work done on behalf of the Board. Ms. Cassetta clarified that a Medical Consultant can get one hour of CME credit for work done for the Board on an hour per hour basis, not one hour per year as alleged by G.K.. Ms. Cassetta stated Dr. Kennell was well in excess of the required CME hours.

MOTION: Patrick N. Connell, M.D. moved to uphold the Executive Director's Dismissal.
SECONDED: William R. Martin, III, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0865A	W.M.	PAUL A. BABEY, M.D.	20364	Uphold the Executive Director's Dismissal.
3.	MD-04-0865B	W.M.	PAUL K. BIRNEY, M.D.	30766	Uphold the Executive Director's Dismissal.

Legal Counsel Richard Rae, for Paul Birney, M.D. spoke during the Call to the Public. Mr. Rae said he believes the complaint is a case of mistaken identity and Dr. Birney had not seen the patient.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-04-0727A	Y.M.	JEFFREY J. PTAK, M.D.	12948	Uphold the Executive Director's Dismissal.

Complainant Y.M. was present and spoke at the Call to Public. She alleged permanent skin damage from a chemical peel three and a half years ago. Y.M. stated the consent forms were misleading as she understood the form was a requirement and that she was not consenting because the form did not specifically call for her consent. She stated the physician did not inform her that he was performing a chemical peel. She stated the risks were not explained. She stated the nurse did not know condition of the patient's skin, although the information should have been recorded in the chart. Dr. Ptak did not respond to Y.M.'s request for information about how many milligrams and what type of chemical was used on her skin. She stated Dr. Ptak's medical records are false. Y.M. stated she has suffered emotional pain as a result.

Tim B. Hunter, M.D. pulled this case for discussion and stated the he knew the patient was upset and there did seem to be a communication issue with the patient and the physician. However, he noted the Medical Consultant's did not find a failure to meet the standard of care in the case.

MOTION: Patrick N. Connell, M.D. moved to uphold the Executive Director's Dismissal of the case.
SECONDED: William R. Martin, III, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-04-0960A	W.J.	STEPHEN S. ABLE, M.D.	20277	Uphold the Executive Director's Dismissal.

W. J., husband of patient R.J., was present and spoke during the call to the public and requested continuing investigation and monitoring of Dr. Able. W.J. stated patient R.J. was in the hospital under a court order maintaining she was a danger to herself and not able to make logical decisions on her own. Shortly after this, Dr. Able had the patient sign release forms. W.J. stated he felt he should have signed the release forms for his wife since she was unable to make logical decisions at that time. W.J. also stated Dr. Able did not inform him or his wife's primary care physicians of his decisions in her care. Dr. Able told the husband he cold not inform him of his decisions if he was not "power of attorney" for the patient.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0014A	R.B.	STEPHEN R. ROSENTHAL, M.D.	21858	Uphold the Executive Director's Dismissal.
7.	MD-04-0939A	S.H.	JOHN V. WOELLNER, M.D.	12440	Place on the agenda for the next Board Meeting with a recommendation for an Advisory Letter.

Paul M. Petelin, Sr., M.D. pulled the case for discussion. The complainant alleged she was overcharged and the physician did not thoroughly examine her or even use a stethoscope. Dr. Petelin stated the medical records were not thorough, as the physician did not elaborate on the patient's smoking history for the past 50 years and did not do a chest x-ray. Dr. Petelin also noted there was no documentation that the services rendered were appropriate for the charges.

Ram R. Krishna, M.D. said the physician did document some notes although they were not thorough. Dr. Krishna said it would be harder to argue the physician did not do an examine that that he did not do a thorough exam.

Dona Pardo, R.N., Ph.D. asked Mark Nanney, M.D., Chief Medical Consultant, about his review of the case. Dr. Nanney said multiple consultants reviewed the case came to different conclusions about the credibility of the parties. Some of the consultants found the physician to be credible while others found the complainant to be credible. Dr. Nanney said he was unable to make a determination about the truth of the case by only reviewing the file and so he felt the case was a credibility issue more than a charting issue.

Ms. Cassetta read the definition of the Current Procedural Terminology (CPT) code that the physician used for the exam. Tim B. Hunter, M.D. stated the code used for the billing seemed to be excessive for what was written in the medical record.

Becky Jordan, commented that the patient deserved a full examination, especially for a first patient visit, regardless of what she was charged.

MOTION: William R. Martin, III, M.D. moved to place the matter on the agenda for the next meeting as an Advisory Letter.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-04-1074A	M.W.	ALFREDO GUEVARA, M.D.	11435	Uphold the Executive Director's Dismissal.

Dr. Guevara was present without counsel and spoke during the Call to The Public. Dr. Guevara stated patient M.W. received a diagnosis of curable prostate cancer. The complaint alleged untimely information was provided to him that resulted in his delay of treatment. The physician stated the allegation is not true and because the patient was diagnosed and treated early, the patient is now recovered.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-04-1456A	D.M.	JOHN R. CROWELL, M.D.	7169	Uphold the Executive Director's Dismissal.
10.	MD-04-1226A	M.B.	KEVIN J. RENFREE, M.D.	26339	Uphold the Executive Director's Dismissal.
11.	MD-05-0468A	C.A.	EDWARD B. DIETHRICH, M.D.	6034	Uphold the Executive Director's Dismissal.
12.	MD-05-0105A	J.L.	JEZEF ZOLDOS, M.D.	28314	Uphold the Executive Director's Dismissal.

Paul M. Petelin, Sr., M.D. and William R. Martin, III, M.D. recused themselves from this case.

13.	MD-04-0890A	G.S.	MICHAEL A. LIPTON, M.D.	11223	Uphold the Executive Director's Dismissal.
14.	MD-04-1090A	L.R.	SCOTT A. KRASNER, M.D.	16269	Uphold the Executive Director's Dismissal.

L.R. was present and spoke during the Call to the Public. She said she was terminated from employment leaving her with no medical and dental insurance because of the recommendation of Dr. Krasner that she work a different job due to her tendonitis.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-03-1255A	M.C.	ROBERT D. CASTILLO, M.D.	11036	Uphold the Executive Director's Dismissal.
16.	MD-04-1466A	D.D.	JEFFERY M. GREENBERG, M.D.	30905	Uphold the Executive Director's Dismissal.
17.	MD-04-0457A	J.T.	RAFAEL V. MARTIN, M.D.	20255	Uphold the Executive Director's Dismissal

Ingrid Haas, M.D., Medical Consultant, presented the case to the Board. Patient J.T. was a 32-year-old patient under prenatal care. The patient had a rupture of membranes that triggered labor and she was monitored at Phoenix Baptist Hospital by midwife staff. Dr. Martin became involved during the second stage of labor and assisted in the patient's request for intervention by vacuum delivery. The Outside Medical Consultant concluded there were no quality of care issues.

MOTION: Ram R. Krishna, M.D. moved to uphold the Executive Director's Dismissal of the case.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-04-1537A	C.A.	SATINDER S. PUREWAL, M.D.	26854	Uphold the Executive Director's Dismissal.
19.	MD-04-1242A	V.D.	ANNA S. SCHERZER, M.D.	9862	Uphold the Executive Director's Dismissal.

MOTION: Patrick N. Connell, M.D. moved to uphold the Executive Director's Dismissal of cases 2, 3, 6,8,9,10,11,12,13,14,15,16,18, and 19.
SECONDED: Ronnie R. Cox, Ph.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0279A	AMB	JOSE ALVAREZ, M.D.	21702	Accept the Findings of Fact and Conclusions of Law for a Letter of Reprimand for removing a healthy ovary during a laparoscopic hysterectomy.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0581A	AMB	LEANDRO F. BATERINA, JR., M.D.	26528	Accept the Findings of Fact, Conclusions of Law and Order for a Ten Year Probation requiring compliance with the terms of the North Dakota Medical Board Order for rehabilitation and shall not practice clinical medicine in Arizona until such rehabilitation is complete.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0769A	N.D.	STUART Z. LANSON, M.D.	7318	Accept the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for misdiagnosis of vasculitis in part on the basis of unconventional testing and recommending unconventional therapy and a civil penalty of $5,000.00.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-03-0437A	AMB	ANCA M. MARAS, M.D.	13103	Accept the Finding of Fact Conclusions of Law and Order for and Decree of Censure and Probation of five (5) years; practicing in a group setting with random chart reviews and quarterly compliance declarations. Dr. Maras can request the Board lift the restriction after two years.

Anca M. Maras, M.D. was present with counsel, Mr. Joseph Kendhammer and spoke during the Call to The Public. Mr. Kendhammer said The PACE II evaluation found Dr. Maras to be competent and able to effectively perform anesthesia. Mr. Kendhammer said they are concerned the Order will end Dr. Maras' career because hospitals and medical groups will not want to accept her, regardless of her medical competence. Mr. Kendhammer said Dr. Maras does acknowledge and accept practice limitations, regardless of her vigorous defense to the Board. Finally, Mr. Kendhammer said the Consent Agreement is vague about defining a "group practice" and what compliance reports should entail.

Douglas D. Lee, M.D. pulled this case for discussion.

Dr. Maras said she takes the Board's concerns seriously, has had no other patient complaints and asks for a second chance for a license without Probation.

Dr. Lee stated Board Order was clear. Ms. Cassetta informed the Board that the definition of group practice is sufficiently stated. Ms. Cassetta also informed the Board that Dr. Maras can ask Staff for assistance. William R. Martin, III, M.D. stated looser language is to the physician's advantage rather than disadvantage

MOTION: Douglas D. Lee, M.D. moved to accept the order as written.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-0
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-04-0100A	AMB	MARK R. MOURITSEN, M.D.	28909	Accept the Findings of Fact, Conclusions of Law for Decree of Censure and Probation for five (5) years; practice with a partner who will review his medical records and medication logs and submit quarterly reports to the Board of his findings. Shall also participate in the Board's MAP program. Shall not prescribe Schedule II medications. Dr. Mouritsen shall receive credit for his current participation under the Interim MAP Agreement.

Lorraine Mackstaller, M.D. stated she knows Dr. Mouritsen but it will not affect her ability to adjudicate the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-04-0493B	AMB	JUSTIN F. WEISS, M.D.	9418	Accept the Findings of Fact, Conclusions of Law for Letter of Reprimand for failure order further diagnostic studies and failure to diagnose a malignant breast mass.

Robert P. Goldfarb, M.D. recused himself from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-04-0484A MD-04-1010A	M.R. M.B.	HOWARD LEE MITCHELL, III, M.D.	30004	Accept the Findings of Fact, Conclusions of Law for a Letter of Reprimand and one (1) year Probation for inadequate medical records and excessive prescribing of narcotics. Probation includes CME in record keeping through the PACE course and CME for pain management. The CME is in addition to the requirements for biennial renewal.

MOTION: Ram R. Krishna, M.D. moved to accept the Draft Findings of Facts, Conclusion of Law and Order for items 1,2,3,5,6,7.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-04-0759A	AMB	SCOTT S. WEISS, M.D.	20073	Accept the Consent Agreement for a Letter of Reprimand for prescribing a prescription only medication on the Internet.

Robert P. Goldfarb, M.D. stated he knows Dr. Weiss but it will not affect his ability to adjudicate the case.

9.	MD-04-0440A	AMB	RICHARD H. DALEY, M.D.	4689	Accept the Consent Agreement for Letter of Reprimand for failure to choose appropriate fixation device and failure to appropriately affix the device.

Paul M. Petelin, Sr., M.D. and William R. Martin, III, M.D. stated they know Dr. Daley but it will not affect their ability to adjudicate the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-03-0446A	AMB	PAUL S. BERGESON, M.D.	6872	Accept the Consent Agreement for Practice Limitation banning him from practicing any clinical medicine or any medicine involving direct patient care and is prohibited from prescribing any form of treatment until the Board approves his return to practice of clinical medicine. The Board may require evaluations to determine if the physician is fit to resume such practice.
11.	MD-05-0022A	SCPIE	RICHARD WHITMAN JR., M.D.	14188	Accept the Consent Agreement for a Letter of Reprimand for failure to perform a thorough evaluation of a patient and failure to obtain the results of a STAT abdominal film.

Paul M. Petelin, Sr., M.D. stated he knows Dr. Whitman but it will not affect his ability to adjudicate the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-03-1173A MD-04-1433A	D.K.	GEORGE B. GRIM, M.D.	4632	Accept consent agreement for surrender of license.

George B. Grim, M.D. was present at the Call to the Public. Dr. Grim stated he would like to surrender his license although he feels the allegations brought against him were a result of a bitter divorce. Dr. Grim stated he was unable to keep adequate patient records after he retired due to a disability and has not been competent to practice medicine since his stroke of 1991. He admits his mistakes and incompetence to continue the practice of medicine due to his health.

W. H. spoke during the Call to the Public on behalf of the physician. W.H. stated his initials are referred to in the Findings of Facts and that he is not ill, as stated in the Board Order. W.H. stated he does not want a black mark on the physician's record and is thankful to Dr. Grim for his good patient care.

MOTION: Robert P. Goldfarb, M.D. moved to accept the Consent Agreement for Surrender of license.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Member was absent: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-04-1395A	AMB	PAUL L. RODRIGUEZ, M.D.	4734	Accept the Consent Agreement for a stayed Suspension and five (5) year Practice Restriction barring him from supervising any physician assistant.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-03-0951A	AMB	RICHARD A. SILVER, M.D.	5135	Accept the Consent Agreement for a Letter of Reprimand for performing a closed reduction and casting that resulted in loss of full pronation and supination of a forearm.

Tim B. Hunter, M.D. and Robert P. Goldfarb, M.D. stated they know Dr. Silver but it will not affect their ability to adjudicate the case.

MOTION: Ram R. Krishna, M.D. moved to accept the Proposed Consent Agreements for items 8, 9,10,11,13, and 14.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Paul M. Petelin, Sr., M.D., The following Board Member was absent: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-03-0363A MD-03-0405A	J.H. AMB	PARMESHWAR M. KHAMRE, M.D.	12905	Rescind referral to formal hearing and accept consent agreement for surrender of license.

Dean Brekke, Board Legal Counsel summarized the case for the Board. Two separate patients brought complaints to the Board alleging that Dr. Khamre fondled them. The Board voted to summarily suspended the license in 2003, but the formal hearing was delayed because at the same time Dr. Khamre was facing criminal charges. After the Board voted to suspend the license, several other complainants came forward with the same allegations. Dr. Khamre plead guilty earlier this year to many of the charges and signed the consent agreement for surrender of license. Mr. Brekke recommended the Board accept the surrender and rescind the referral to formal hearing. He also recommended dismissal of case MD-03-0363A based on the complainant moving out of the state and the Board's inability to contact her. Mr. Brekke also recommended dismissal of the first case based on the consent agreement for second case.

Christine Cassetta, Board Legal Counsel, informed the Board that when a Formal Hearing is rescinded it returns the cases to the agency. She advised the Board not to dismiss the case, but to defer dismissal to the Executive Director.

MOTION: Ram R. Krishna, M.D. moved to rescind referral to formal hearing and accept consent agreement for surrender of license.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D.
The following Board Members were not present: Douglas D. Lee, M.D., Ronnie R. Cox, Ph.D., Sharon B. Megdal, Ph.D.
VOTE: 9 yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-04-L212A	AMB	DANIEL L. VANDIVORT, M.D.		Denial of License.

Mark Nanney, M.D. Chief Medical Consultant, summarized the case. Dr. Vandivort may not be medically capable to practice medicine. Several physicians have assessed Dr. Vandivort's abilities and all conclude there are deficits and each found a deficit to a different degree. One physician states Dr. Vandivort has a visual impairment and seems unaware of the impairment. A therapist stated Dr. Vandivort's vision does not impair him. A physician who saw Dr. Vandivort in September of 2004, stated he has several problems, but Dr. Vandivort compensates well and can return to practice without surgery. A physician who assessed the applicant in May of 2005 noted mild deficiencies, discrimination deficiencies and unawareness of those errors, and a slowed processing speed. The physician who performed the most recent assessment declined to say whether Dr. Vandivort could return to work.

Ram R. Krishna, M.D. noted that practicing in an office is not easy even with full abilities.

Tim B. Hunter, M.D. verified with Board Staff that this was a new applicant and not a renewal of license.

MOTION: Ram R. Krishna, M.D. moved to deny the license A.R.S. § 32-1422(A)(3)- Have the physical and mental capability to safely engage in the practice of medicine, A.R.S. § 32-1422 (B)- The board may require the submission of such credentials or other evidence, written and oral, and make any investigation it deems necessary to adequately inform itself with respect to an applicant's ability to meet the requirements prescribed by this section, including a requirement that the applicant for licensure undergo a physical examination, a mental evaluation and an oral competence examination and interview, or any combination thereof, as the board deems proper.
SECONDED: Patrick N. Connell, M.D.

Douglas D. Lee, M.D. clarified that legal blindness was not the only issue, but that the cognitive defects were also in question.

Dona Pardo, R.N., Ph.D. asked Christine Cassetta, Board Legal Counsel if the Board voted to deny the license if the physician could re-apply. Ms. Cassetta noted he could re-apply.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Member abstained from voting: Ronnie R. Cox, Ph.D. The following Board Member was not present: Sharon B. Megdal, Ph.D.
VOTE: 10 yay, 0-nay, 1-abstain/recuse, 1-absent.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-03-L162A	AMB	TIMOTHY N. KLEIN, M.D.	32213	Terminate Probation

Chris Banys from the Monitored Aftercare Program presented the case to the Board regarding Dr. Klein's request for Termination of Probation. Dr. Klein was monitored by the Board for three years under his Residency Permit and was placed on a five-year Probation when he obtained his permanent license in Arizona. In 2004 he relocated to New Mexico and participated in the New Mexico Board's Monitored Treatment Program. Dr. Klein returned to Arizona in 2005 and asked that he be granted a three year credit for his monitoring in New Mexico. Ms. Banys said Dr. Klein has been in full compliance with the terms of the Probation.

Dr. Sucher said Dr. Klein has been sober for approximately five and a half to six years and has been monitored during his entire sobriety. Dr. Sucher said the physician is stable and further monitoring is not required.

MOTION: Patrick N. Connell, M.D. moved to terminate the Probation.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 9 yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-03-0184A MD-03-0370A	AMB	WILLIAM M. COCHRAN, M.D.	15469	No action was taken.

Kathleen Muller, Senior Compliance Officer summarized the case. On June 11, 2003 Dr. Cochran entered into a Consent Agreement for Practice Restriction, Probation and a Decree of Censure. Part of the Order's restrictions were that Dr. Cochran not be permitted to practice pain management. Dr. Cochran requested the pain-management restriction be lifted.

Michel Sucher, M.D., Addictionologist for the Board said Dr. Cochran has been fully compliant with the Board Order and has had a solid recovery to date. Dr. Sucher said the physician will remain on Probation for another three years whether or not the restriction is lifted. Dr. Sucher also said now would be a good time to lift the restriction while the physician is being monitored by the Board.

Patrick N. Connell, M.D. noted Dr. Cochran had been in treatment twice, but that it was difficult to tell if the physician had relapsed two or three times.

William R. Martin, III, M.D. said granting the doctor the privilege of practicing pain management may not better serve the community. Dr. Martin commented that for the few patients Dr. Cochran would be seeing, in the small town where he wants to practice, a large amount of harm could be done.

Dona Pardo, R.N., Ph.D. said her understanding of Dr. Sucher's recommendation was that the time to lift the restriction would be while the physician is on Probation and continually monitored.

MOTION: Patrick N. Connell, M.D. moved to lift the pain management restriction.
SECONDED: Becky Jordan
VOTE: 4 yay, 5-nay, 0-abstain/recuse, 3-absent
MOTION FAILED.

William M. Cochran, M.D. must continue to abide by the pain management restriction.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-02-0749A	AMB	HARA P. MISRA, M.D.	14933	Deny Motion for Rehearing

Ram R. Krishna, M.D. recused himself from the case.

Stephen Wolf, Assistant Attorney General, noted he found the petition to be without merit and recommended denial of the rehearing.

MOTION: Patrick N. Connell, M.D. moved to deny the motion for rehearing.
SECONDED: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-04-0128A	AMB	ADAM F. FEINGOLD, M.D.	23246	Deny Motion for Rehearing

Stephen Wolf, Assistant Attorney General, noted Dr. Feingold alleged the Outside Medical Consultant who reviewed the case and the Board member who led the questioning in the case were not qualified to judge the matter. Mr. Wolf said the Outside Medical Consultant and Board member who led the questioning were both Board Certified in the specialty pertaining to the case and were well qualified to judge the matter.

MOTION: Ram R. Krishna, M.D. moved to deny the motion for rehearing.
SECONDED: William R. Martin, III, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-05-L025A	AMB	JEFFREY A. HALL, M.D.		Deny the application for license.

William R. Martin, III, M.D. sated he knows Dr. Hall but that will not affect his ability to adjudicate the case.

Dr. Hall was present and spoke during the call to the Public. He stated he became arrogant during his residency program and believed that he did not need assistance from other physicians. He stated that because of this arrogance, he accepted a position in rural Arkansas and was convinced he ran the practice competently. However, in hindsight he realizes the situation alleged in the complaint could have been handled appropriately if he had the advantage of a physician team approach. Dr. Hall stated that after the incident he moved to practice with a larger hospital with more support with all team players present and necessary to practice competent medicine.

Dr. Hall also addressed his issue with controlled substances. Dr. Hall stated he entered into an agreement with Arkansas Board for random testing and has been successfully released from the program. Dr. Hall asked that a license be granted to practice in the State of Arizona.

William Wolf, M.D., Board Medical Consultant summarized the case. Dr. Hall applied for a license and had three malpractice cases. After reviewing the malpractice cases the license was denied by the Executive Director. One malpractice case alleged Dr. Hall removed a healthy gallbladder in a patient, another case alleged unnecessary laparoscopic surgery was performed that caused damage to the small bowel. The third malpractice case alleged the physician unnecessarily performed an abdominal resection for cancer, before confirming the presence of cancer and the final pathology showed the patient did not have cancer. The Consultant stated the physician deviated from the Standard of Care for the above mentioned cases and that there were no mitigating factors.

Tim B. Hunter, M.D. asked Marlene Young, Senior Medical Investigator, about the probation order in the state of Arkansas for monitoring of substance abuse. Ms. Young stated the physician was only monitored by the Arkansas Board for a period of ten months before he moved and is not currently monitored.

Tim B. Hunter, M.D. does not believe the physician met the standard of care in his malpractice cases and did not think he should obtain a license to practice in Arizona.

MOTION: Ram R. Krishna, M.D. moved to uphold the Executive Director's decision to deny the license based on a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (o)- Action that is taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's mental or physical inability to engage safely in the practice of medicine, the doctor's medical incompetence or for unprofessional (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public (ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient and (f)- Habitual intemperance in the use of alcohol or habitual substance abuse.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Member abstained from voting: William R. Martin, III, M.D. The following Board Member was not present: Sharon B. Megdal, Ph.D.
VOTE: 10-yay, 0-nay, 1-abstain 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
22.	MD-05-S004A	AMB	CARMAN H. BROOKS, M.D.	9126	Grant the request for Inactivation of License.

The Board went into Executive Session at 5:58 p.m.
The Board returned to Open Session at 6:08 p.m.

MOTION: Ram R. Krishna, M.D. moved to grant the request for Inactivation of License.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 8-yay, 1-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
23.	MD-03-0248A MD-04-0081A	AMB	W. NEIL CHLOUPEK, M.D.	4553	Refer the matter to Formal Hearing for Revocation

W. Neil Chloupek, M.D. was present with legal counsel Bill Gibney.

Kathleen Muller, Physician Health Program Manager, presented the case to the Board. On November 22, 2004 the Board Ordered a Stayed License Revocation and Indefinite Suspension due to relapse. The Board ordered Dr. Chloupek physician to undergo inpatient treatment within one year and enter the Monitored Aftercare Program (MAP) with the Board following treatment. Dr. Chloupek was treated by The Betty Ford Center on February 16, 2005 through April 21, 2005 and was discharged with a diagnosis of Opiod and Ritalin dependence in early full remission in a controlled environment. The Betty Ford Center recommended the physician successfully participate in the MAP program for six months before returning to practice. The Betty Ford Center also stated Dr. Chloupek should never again take Opiod or Ritalin drugs. On April, 26, 2005 Dr. Chloupek requested to return to practice and was offered an Interim Proposed Consent Agreement to participate in MAP pursuant to Betty Ford's recommendations. The physician's attorney advised him not to sign the Consent Agreement, but to rather see a psychiatrist in order to obtain medication for his depression and Attention Deficit Hyperactivity Disorder (ADHD). On May 26, 2005 Dr. Chloupek was given a Confidential Interim Order for Biological Fluid Testing. The drug screen tested positive for Hydrocodone. Additionally, the physician listed Ritalin and Lorcet on the Chain of Custody form as medications taken within the past seven days. Ms. Muller summarized by saying Dr. Chloupek had not been monitored by the Board Staff since he left The Betty Ford Center, with the exception of the one drug screen.

Mr. Gibney summarized his experience with ADHD and Depression in regard to his family's personal experience. Mr. Gibney stated he advised his client not to sign the Consent Agreement to enter into MAP because he felt the physician needed Ritalin and would not be able to function without it. Mr. Gibney stated The Betty Ford Center deals with addictions and not depression and therefore their recommendations cannot be considered in his client's case. Mr. Gibney presented a report from Dr. Barlow who stated Dr. Chloupek had issues of depression and that a prescription to treat the depression may be helpful. Mr. Gibney stated Dr. Chloupek is now back on Ritalin and is doing well. Mr. Gibney also defended his client's need for pain medications because of Dr. Chloupek's five knee replacements. Mr. Gibney requested the lifting of the Suspension Order and placement of Dr. Chloupek into the MAP program.

Dr. Chloupek stated he cannot take substitute drugs for his ADHD or depression because he has tried many different drugs and has had adverse reactions. Dr. Chloupek also stated he has not had any drug or alcohol dependence problems since 1984.

David Greenberg, M.D. Board Addictionologist, said he was a witness for the Board when the case went to Formal Hearing and the judge recommended Dr. Chloupek's license be revoked. Dr. Greenberg said he could not see how the MAP program could be an option for this physician because the MAP program is abstinence based. Dr. Greenberg also stated there were facts not mentioned by the attorney and the physician in their opening testimony one of which was the Arrest of Dr. Chloupek in 1986 for narcotics and for the possession of empty bottles of Ritalin. Dr. Greenberg said the physician has been disciplined by Board in the past for dangerous prescribing of amphetamine. Dr. Chloupek also inappropriately gave narcotics to a physician in the MAP program, aiding in the physician's relapse. Dr. Chloupek has obtained Ritalin by presenting to various physicians and claiming various complaints. Dr. Greenberg said he spoke to Dr. O'Conner, a member of Betty Ford's staff, about an hour before Dr. Chloupek presented his case to the Board. Dr. O'Conner stated the observation of Betty Ford's staff was that Dr. Chloupek did well in Betty Ford, was able to function and think without Ritalin and could walk quite well without a limp or signs of pain, without being on pain medications. However, when Dr. Chloupek noted he was being observed by the Betty Ford staff, he began to manifest a significant limp.

Mr. Gibney stated Dr. Chloupek's record has been cleared for arrest and the arrest should not be considered by the Board.

MOTION: William R. Martin, III, M.D. moved to go into executive session for legal advice.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-0

The Board went into executive session at 4:42 p.m.
The Board returned to open session at 4:48 p.m.

Dr. Martin stated that by the physician's own testimony he has relapsed and is continuing to take his drugs of choice.

Dr. Connell said the physician has had a long history with drugs and with the Board and the only course of action now is revocation of the license because the physician cannot be monitored in MAP.

MOTION: William R. Martin, III, M.D. moved to refer the matter to Formal Hearing for Revocation.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9 yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
24.	MD-04-1085A	AMB	MARYAM JABERI, M.D.	32947	Lift the Practice Limitation

Tim B. Hunter, M.D. stated there is credible evidence the physician is practicing good medicine at this point as presented by Board Staff.

MOTION: Patrick N. Connell, M.D. moved to lift the Practice Limitation.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
25.	MD-04-0382A	AMB	PAUL A. AUPPERLE, M.D.	30485	Accept the Consent Agreement for a Letter of Reprimand for habitual intemperance with five (5) years Probation and continued participation in MAP with credit of time served in MAP while under Interim Order.

MOTION: Patrick N. Connell, M.D. moved to accept the Consent Agreement.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Member was absent: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
26.	MD-04-0932A	S.H.	MICHAEL EPNER, M.D.	24722	Table the matter until the next meeting

The Board requested to table the matter until the next meeting.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
27.	MD-04-0894A	AMB	CHARLES A. BOLLMANN, M.D.	6020	Reject the consent agreement and offer a revised consent for a Decree of Censure for self-prescribing and 10 hours CME related to ethics for admitted sexual conduct with patients and admitted self-medicating. The agreement would include a five year Probation for Psychosexual counseling with a Board approved therapist. If doctor declines the consent agreement he will be invited for a formal interview.

Dona Pardo, R.N., Ph.D. commented that there were two issues, the self prescribing and the sexual boundary issue and that in the past she thought the Board would take a more severe action than the proposed consent agreement. She also commented, along with Robert P. Goldfarb, M.D. that the Consent Agreement did not list all of the Board's findings.

MOTION: Dr. Goldfarb made a motion to reject the consent agreement and offer a revised consent for a Decree of Censure for self-prescribing and 10 hours CME related to ethics for admitted sexual conduct with patients and admitted self-medicating. The agreement would include a five year Probation for psychosexual counseling with a Board approved therapist. If doctor declines the consent agreement he will be invited for a formal interview.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D. The following Board Member was absent: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0720A	R.D.	ZELALEM YILMA, M.D.	25431	Continue the matter to renotice the physician on the medical record keeping issue.

R. D., husband of J.C., spoke during the Call to the Public. R.D. summarized his complaint by stating his two main allegations of medical errors. Specifically, he noted Dr. Yilma's failure to place a dual-chamber pacemaker and her failure to request assistance with the procedure when it became difficult. R.D. commented that prior to surgery his wife was prescribed a dual-chambered pacemaker by Dr. Yilma's colleague. However, due to difficulties during the surgery, Dr. Yilma opted to place a single chamber pacemaker. R.D. alleges the single-chambered pacemaker led to his wife's worsening condition after the procedure. R.D. stated his wife had to be admitted to the hospital for congestive heart failure. A new cardiologist was obtained whom the patient felt proved the necessity of dual-chamber pacemaker. The new cardiologist placed the dual chamber pacemaker and patient J.C. now has a better quality of life.

Dr. Yilma was present with legal counsel, Mr. Steve Meyers.

William Wolf, M.D. Medical Consultant presented an overview of the case. The case was brought to the Arizona Medical Board on June 4, 2004 by complainant R.D. alleging inappropriate care of his wife. R.D. alleged failure to meet standard of care in the implantation of pacemaker by placing a single lead instead of two leads and secondly, placing the lead in front of the pacemaker when standard of care required placement behind the pacemaker. It was also alleged Dr. Yilma failed to diagnose pacemaker syndrome although there was clear presence of the syndrome in Dr. Yilma's medical records. The final allegation was failing to seek assistance during the procedure when complications occurred. An Outside Medical Consultant reviewed the case and stated the standard of care is to install dual chambered pacemaker with two leads and that Dr. Yilma deviated by placement of only one lead. The Outside Medical Consultant also stated that Dr. Yilma deviated from the standard of care by placing the lead wire in front of the pacemaker rather than behind it. Additionally the Outside Medical Consultant concluded Dr. Yilma failed to apply the correct principles in order to diagnose pacemaker syndrome. Finally, the Consultant stated Dr. Yilma deviated from the standard of care by not seeking assistance with the procedure when needed. The Outside Medical Consultant felt a mitigating factor was that the patient's symptoms were not straightforward following the pacemaker placement. An Interview was conducted with Dr. Yilma after which the Outside Medical Consultant still maintained the Standard of Care was breached.

Dr. Yilma stated when she placed the pacemaker she placed a ventricular lead and then attempted to place an atrial lead. After multiple attempts to place the atrial lead, she noticed the patient was having significant blood loss so she stopped to asses the necessity of the atrial lead. Dr. Yilma stated although dual chamber is traditionally thought to be better than the single-chambered pacemaker randomized studies have not proven that. She further stated the patient's condition was such that inserting a ventricle lead and leaving it as a back up would suffice in preventing articular asystole. Thirdly, in the event the patient needed an upgrade, one could be arranged under better circumstances. Finally, consideration was taken that the patient would be placed in harm's way by continuing the procedure. Dr. Yilma stated her decision to secure the ventricular lead was in the patient's best interest and was backed by evidence based medicine and was within the standard of care. Therefore the allegation that she needed to call for assistance with the procedure becomes a moot issue.

Dr. Yilma stated the patient was discharged from the hospital and seen by her twice within less than one month. Shortly thereafter her continuing care was cut off due to a change in the patient's insurance. The patient had no signs or symptoms for pacemaker syndrome while under Dr. Yilma's care as proven by the very low pacemaker activity noted during the pacemaker check.

Lorraine Mackstaller, M.D. led the questioning. Dr. Yilma stated she had placed 250 pacemakers within last three years. Dr. Yilma said that if patients are paced by maintaining AV synchrony, homodynamics should improve, but clinical trials have not proven that. Dr. Yilma further stated the patient required pacing only intermittently and the procedure was primarily preventative.

Dr. Mackstaller inquired about Dr. Yilma's documentation of what types of wires she attempts during a procedure. Dr. Yilma said it is not routine for her to say what type of wire she attempts to use, but she does dictate serial numbers of the wires and feels the follow up cardiologist made an assumption when he alleged she did not attempt a particular wire.

Dr. Mackstaller noted that Dr. Yilma failed to document the patient's complication of excessive bleeding during the procedure. Dr. Yilma stated she does not usually dictate whether the wire is placed in front or behind because it does not make a difference in pace function.

The Board members then viewed the X-rays to see where the pacemaker was initially placed. Dr. Mackstaller stated that, according to the x-ray, it appears the wire placed posteriorly the day after generator was placed, and three months later it migrated anteriorly and asked Dr. Yilma if that was a known complication. Dr. Yilma stated she did not consider it to be a complication because pacemaker still can function well. Dr. Macksteller inquired about the development of the patient's pacemaker syndrome and asked Dr. Yilma to describe the difference between congestive heart failure and pacemaker syndrome. Dr. Yilma stated it is difficult to make a diagnosis without excluding all other possibilities first. Dr. Mackstaller also asked how long after placement of a pacemaker can a patient develop pacemaker syndrome. Dr. Yilma replied it is based on percentage of pacing.

Robert P. Goldfarb, M.D. asked Dr. Yilma to clarify her primary reason for aborting the procedure. Dr. Yilma stated the patient's bleeding was the primary reason to abort. Dr. Goldfarb also questioned her lack of documentation on the operative report in noting why the procedure was aborted. Dr. Goldfarb noted that another physician would not have adequate notes to follow if Dr. Yilma became unavailable.

Paul M. Petelin, Sr., M.D., reiterated the previous Board Members' concern about the patient's blood loss not being documented in the operative report and asked if the physician did a coagulation study on the patient prior to the implantation of the pacemaker. Dr. Yilma stated she had performed the coagulation study.

Ram R. Krishna, M.D., asked Dr. Yilma how long she had been the patient's physician. Dr. Yilma stated she was the patient's cardiologist for a few months before the placement of the pacemaker and just under one month following the procedure. Dr. Yilma replied that while the patient was under her care there were no signs or symptoms of congestive heart failure.

William R. Martin, III, M.D. questioned Dr. Yilma on whether or not the medical billing global time frame had expired when the patient transferred to a new physician with her new insurance plan in order to determine whether the patient could have been under Dr. Yilma's care for a longer period of time. Dr. Yilma replied that she did not know the length of the global time frame.

Tim B. Hunter, M.D. stated he did not find thorough notes about the patient's blood transfusion while in the hospital. Dr. Yilma stated she did not order the blood transfusion for the patient because another cardiologist in her group took over the patient's care the day after the patient was discharged from the hospital.

Dr. Yilma's legal counsel, Mr. Meyers, commented that he had not prepared his client for a rebuttal regarding the Board's concern for her incomplete medical records because the Board had not noticed for that allegation. Dr. Meyers further stated the Outside Medical Consultant's opinion that Dr. Yilma deviated from the standard of care should not be upheld because the Consultant did not consider the same literature that Dr. Yilma presented to the Board in her rebuttal. Secondly, Mr. Meyers felt the Outside Medical Consultant arrived at a misinformed decision about the placement of the wire because the consultant did not review the initial film. Finally, Mr. Meyers stated three qualified experts agree with Dr. Yilma's care and the case should be dismissed.

Dr. Mackstaller stated she did not see where Dr. Yilma deviated from the standard of care, but there were deficits in the records. Dr. Mackstaller asked Christine Cassetta, Board Legal Counsel if they could proceed with a motion since the physician had not been noticed for that allegation. Ms Cassetta advised the Board that their two options with the case were to either continue the matter to a future Board meeting or to ask Dr. Yilma's to waive notice her regarding her medical record keeping. Mr. Meyers stated they would not be willing to waive the notice and would like time to prepare to more thoroughly to answer the Board's questions regarding the chart documentation.

Dr. Mackstaller commented she did not find unprofessional conduct regarding the four allegations. For the first allegation she said the evidence shows a single pacemaker wire is appropriate. Secondly, the wire was placed posteriorly according to the x-ray which is appropriate. Thirdly, there was no data that showed the patient paced sufficiently to generate pacemaker syndrome. And finally, the physician was not in a position where she needed to seek assistance.

MOTION: Lorraine Mackstaller, M.D. moved that the Board not find unprofessional conduct for the four allegations.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-aye, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

MOTION: Lorraine Mackstaller, M.D. moved to continue the matter to renotice the physician on the medical record keeping issue.
SECONDED: Douglas D. Lee, M.D.
VOTE: 11-aye, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0894A	AMB	CHARLES A. BOLLMANN, M.D.	6020	This matter was moved to Other Business #27

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-1399A	AMB	JERALD D. WHITE, M.D.	5146	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for knowingly prescribing to family members so that he could submit the claim to his insurance in lieu of paying child support.

Jerald White, M.D. was present without legal counsel.

Patricia Reynolds, Assistant Manager, Office of Investigations, presented the case to the Board. On November 9, 2005 the Arizona Medical Board received a report from the Federation of State Medical Boards indicating Dr. White received a letter of reprimand from the Medical Board of California for insurance fraud, inappropriate prescribing and controlled substance violations. Dr. White admitted to insurance fraud, specifically prescribing Concerta for his son in his stepdaughter's name for approximately one year, in lieu of paying child support. Dr. White indicated since the time he was noticed by the California Medical Board, he no longer prescribes to members of his family and no longer writes courtesy prescriptions to members at the hospital such as the nurses.

Dr. White addressed the Board and stated he recognizes his conduct was a serious problem and apologies for it. Dr. White stated he has discontinued his inappropriate conduct and has since taken two courses in ethics. He further stated he made restitution to the insurance company for the money for the prescriptions and respectfully asks that he be permitted to maintain his license.

Becky Jordan led the questioning and asked Board Staff why Dr. White was not offered a consent agreement in order to save him a trip out from California. Dr. White replied that he did have the consent agreement, but felt it was best if he appeared before the Board to discuss his case.

Dr. White said he reimbursed the insurance company although he did not profit monetarily for the inappropriate prescribing. Dr. White said he followed the guidelines for the 12 hours of CME in Ethics as mandated by California Board. Dr. Goldfarb asked Dr. White how the California State Board discovered the insurance fraud. Dr. White said he voluntarily notified both the California Board and Insurance company. Dr. White stated he has had no other complaints and has been licensed with the Board since 1969.

MOTION: Becky Jordan moved for a finding of Unprofessional conduct in violation of A.R.S. §32-1401 (27) (a)- Violating any federal or state laws or rules and regulations applicable to the practice of medicine, (h)- Prescribing or dispensing controlled substances to members of the physician's immediate family, (o)- Action that is taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's mental or physical inability to engage safely in the practice of medicine, the doctor's medical incompetence or for unprofessional conduct as defined by that jurisdiction and that corresponds directly or indirectly to an act of unprofessional conduct prescribed by this paragraph. The action taken may include refusing, denying, revoking or suspending a license by that jurisdiction or a surrendering of a license to that jurisdiction, otherwise limiting, restricting or monitoring a licensee by that jurisdiction or placing a licensee on probation by that jurisdiction.
SECONDED: William R. Martin, III, M.D.
VOTE: 11-aye, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

MOTION: Becky Jordan moved to direct Staff to draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for knowingly prescribing to family members so that he could submit the claim to his insurance in lieu of paying child support.
SECONDED: Ronnie R. Cox, Ph.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Member was not present: Sharon B. Megdal, Ph.D.
VOTE: 11-aye, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-04-0236A	C.R.	KENNETH M. FISHER, M.D.	12762	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriate diagnosis and treatment of a skin lesion and for inadequate medical records.

Kenneth Fisher, M.D. was present with counsel Mr. Cal Raup.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. The complainant alleged a bad result after a cryotherapy procedure with Dr. Fisher. Patient C.R. also alleged there was not adequate informed consent and that the procedure was unnecessary. An Outside Medical Consultant reviewed the case and felt the standard of care was to first biopsy a suspicious lesion or proceed with definitive treatment such as cryosurgery if the diagnosis was established. The outside consultant felt the apparent lack of a full informed consent was probably an aberration of the record. But, he felt that the procedure had probably been performed below the standard of care utilizing a technique that he referred to as "old fashioned".

Patrick N. Connell, M.D. stated he knew Mr. Raup, but it would not hinder his ability to adjudicate the case.

Dr. Connell noted that in Dr. Fisher's medical record the patient complained of a growth on her face and of night sweats and asked Dr. Fisher how he approached the night sweats issue. Dr. Fisher stated he interviewed the patient for her night sweats and fever, but informed her she would need a more involved workup for labs on a later day. Dr. Fisher stated the patient did not inform him that her sweats were associated with fever.

Dr. Connell noted Dr. Fisher did not document that the patient complained of night sweats on her first visit and also did not document that the patient mentioned a skin lesion on her face at the same appointment. Dr. Connell noted he was concerned that the record would not indicate, for a follow-up physician, that the growth was present. Dr. Connell said it was below the standard of care to treat a lesion that was not described in

the record. Dr. Connell noted, on a separate visit, the medical record showed a vague diagram of the lesion with a description below it. Dr. Connell noted the diagram was inadequate and the terminology used to describe the lesion was not correct.

Dr. Connell asked about the signed consent form. Dr. Fisher stated he takes responsibility for consents to be signed and believes he had one for the patient, but that it was inadvertently thrown away. Dr. Fisher stated he has taken corrective measures for this incident in several ways.

Dr. Connell asked Dr. Fisher to describe the machine used to for cryotherapy. Dr. Fisher stated he uses a Cryoprobe, with a gel interface and liquid nitrogen that flows the probe.

Dr. Connell asked Dr. Fisher to describe how the scarring and pigment changes occurred on patient C.R. Dr. Fisher said he did not have an explanation and has not seen this happen before. Dr. Connell stated that, based on outcome, there was a deeper freeze than what was necessary. Dr. Fisher contested that pigment changes can occur even without a long freeze.

Robert P. Goldfarb, M.D., asked Dr. Fisher if he felt cryotherapy was the standard of care to treat squamous cell carcinoma. Dr. Fisher stated it was in some instances. Dr. Fisher said the patient refused his suggestion of the biopsy.

Dr. Goldfarb asked about Advisory Letter in 2002 for inadequate medical records, and what he had done specifically since that time. Dr. Fisher stated he has routine audits of his charts, by Board of Medical examiners every three months and no flaws have been sited. Additionally, an outside service comes to audit his charts. Dr. Hunter asked how Dr. Fisher's documentation of personal findings has improved. Dr. Fisher stated he is meticulous in his notes. Dr. Hunter asked Dr. Fisher to summarize his medical training.

Paul M. Petelin, M.D. asked Dr. Fisher if planned to alter his use of cryotherapy in the future. Dr. Fisher stated he would probably defer a similar case to a plastic surgeon, but that he did not believe the cryotherapy procedure was performed incorrectly.

Mr. Timothy Miller, Executive Director, clarified for record that the Board Staff review of Dr. Fisher's medical records has only been to verify that a chaperone has been present with Dr. Fisher. Staff did not check for adequate medical records. Dr. Fisher made the comment Board's Staff has told him his charts looked good during their random visits.

Dr. Connell stated Dr. Fisher fell below the standard of care in that the description of the lesion was inadequate, and the application of cryoprobe was applied for an inappropriate length of time.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) (e)- Failing or refusing to maintain adequate records on a patient and (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-aye, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

MOTION: Patrick N. Connell, M.D. moved to draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriate diagnosis and treatment of a skin lesion and for inadequate medical records.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Paul M. Petelin, Sr., M.D. The following Board Member was absent: Sharon B. Megdal, Ph.D.
VOTE: 11-aye, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

Ronnie R. Cox, Ph.D. left the Board meeting at 12:30 p.m.

CALL TO PUBLIC – 1:15 p.m.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-04-0186A MD-04-0925A	PSYCH BOARD/ W.F.	HOWARD L. MITCHELL III, M.D.	30004	Defer sanction until the next meeting

Dr. Mitchell was present without legal counsel.

Mark Nanney, M.D., Chief Medical Consultant summarized the case for the Board. The case was referred from the Arizona Board of Psychology. Dr. Mitchell did a psychology and custody evaluation. The concerns raised are that Dr. Mitchell's report, failed to consider domestic findings and based interview findings on father's testimony only. The Court concluded Dr. Mitchell failed to give an unbiased report. The Outside Medical Consultant found potential harm based on unfounded custody recommendations.

Robert P. Goldfarb, M.D. led the questioning and asked Dr. Mitchell how he came to do the psychiatric evaluation on behalf of the father and what he thought the purpose of the evaluation was. Dr. Mitchell stated he had seen patient's mother and she referred her son was to him.

Dr. Goldfarb asked Dr. Mitchell if he considered domestic violence to be a psychiatric problem and why the domestic findings in the court records had not been included in his evaluation. Dr. Mitchell stated he was not making a recommendation for custody but was only making a psychiatric evaluation. Dr. Goldfarb noted that Mitchell made assumptions of the wife's motives without evaluating her. Dr. Mitchell stated he was suspicious that the patient was being set-up and recommended the estranged wife be evaluated as well. Dr. Goldfarb also noted Dr. Mitchell

had a long-standing relationship with the patient's mother, but did not put that in the report. Dr. Goldfarb asked Dr. Mitchell if it occurred to him that his report may appear as a biased evaluation. Dr. Mitchell stated that he did not feel there were red flags of biased for the psychiatric evaluation.

Tim B. Hunter, M.D. stated the Dr. Mitchell's report appears as a recommendation to the Court.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) (t)- Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution.
SECONDED: Tim B. Hunter, M.D.

AMENDED MOTION: Robert P. Goldfarb, M.D. amended the motion to include A.R.S. §32-1401 (27) (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Tim B. Hunter, M.D.

VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED

Dr. Goldfarb stated he would like to defer sanction of this case until the next case was heard.

Kelley Sems, M.D., Medical Consultant, summarized the second case for the Board. The case was brought to the Board on July 19, 2004 by W.F. representing patient G.L. The complainant alleged Dr. Mitchell over-prescribed psycho stimulants and failed to provide medical records to an authorized provider. The Outside Medical Consultant supported the allegations and noted Dr. Mitchell failed to consider any other diagnosis for the patient's symptoms and failed to consider the long-term consequences of prescribing psycho stimulants. Consequently, there was patient harm secondary to the long-term stimulant use. The Outside Medical Consultant also noted Dr. Mitchell did not respond to five requests from authorized providers for the patient's medical records. The Chief Medical Consultant also noted that the patient's records were illegible.

Dr. Mitchell saw the patient for Attention Deficit Hyperactivity Disorder (ADHD) and soon learned the patient was getting prescriptions from several physicians. Dr. Mitchell reported the situation to the Drug Enforcement Agency (DEA). The DEA then came to his office and took the patient's medical chart away from Dr. Mitchell's receptionist and kept the chart for several months. Dr. Mitchell stated he saw the patient once after learning the patient was also seeking prescriptions with other providers. It was at that point Dr. Mitchell told the patient he could not prescribe anything further.

Robert P. Goldfarb, M.D. led the questioning and expressed concern about Dr. Mitchell's over-prescribing for the patient, specifically 240 mg of Aderil XR in one day and then prescribing large doses of sleep medication. Dr. Goldfarb noted the patient's sleep problems may have been a result of the Aderil prescription. Dr. Goldfarb noted he did not see vital signs for the patient in Dr. Mitchell's record. Dr. Mitchell stated it is not his practice to do vital signs before prescribing drugs because he refers that procedure to the primary care physician. Dr. Goldfarb asked if he was obtaining the vital signs from the primary care physician and Dr. Mitchell answered he was relying on the patient's verbal history to obtain the information.

Dr. Goldfarb asked why Dr. Mitchell continued to prescribe large doses of psycho stimulants even after the patient's ischemic episode. Dr. Mitchell stated he was trying to get the patient down and off of all the psycho stimulants.

Dr. Goldfarb, noted Dr. Mitchell's medical records were illegible and asked if he had thought of getting a better system that would include implementing a medication sheet for each patient where refills can be easily tracked.

Lorraine Mackstaller, M.D. noted Dr. Mitchell said his patient was rapidly metabolizing his medication because he had an increased lack of attention. However, Dr. Mackstaller said lack of attention can also be an indication that a patient is receiving too much of a drug.

Dr. Goldfarb asked the Board's Chief Medical Consultant, Dr. Nanney, how long Dr. Mitchell continued to prescribe medication to the patient after learning the patient was receiving the medication from another physician. Dr. Nanny stated it was a period of about five to six months. Dr. Goldfarb also asked Dr. Nanney if there was a rule about psychiatrists not taking a patient's vital signs. Dr. Nanney stated there was not.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and (e)- Failing or refusing to maintain adequate records on a patient.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED

MOTION: Dr. Goldfarb moved to defer sanction until the next meeting when the Board's draft Findings of Fact, Conclusions of Law and Order presented from the previous meeting are final.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED

OTHER BUSINESS- 2:45 p.m.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0949	AMB	JAMES D. GADD, M.D.	8696	Continue the matter and invite the physician for a formal interview in December. The practice restriction remains in place.

Kathleen Muller, Senior Compliance Officer summarized the case for the Board. On November 20, 2003 the physician entered into a Consent Agreement for License Reactivation and Probation that stated his license would be revoked upon relapse. On August 3, 2005 the physician tested positive for Fentanyl and admitted to relapse. Dr. Gadd signed an Interim Agreement for Practice Restriction on September 15, 2005. The Board Staff offered Dr. Gadd a Consent Agreement for Surrender of license, but as of today he had not yet signed it.

William R. Martin, III, M.D. stated that he knows Dr. Gadd but will not hinder his adjudicating the case.

Dr. Gadd, was present and was represented by legal counsel, Cal Raup. Dr. Gadd stated two traumatic events lead to his relapse; a break up from a long-term relationship with his fiancée and a law suit with his former employer. Dr. Gadd states he realizes his relapse was a result of a failed recovery. Dr. Gadd said he does not plan to practice clinical medicine in the future, but would like to keep his license so he could practice administrative medicine and would be willing to submit to an evaluation should he decide to return to active medical practice.

Michel Sucher, M.D., Board Addictionologist, spoke regarding his knowledge of the case. Dr. Sucher said in 2003 Dr. Gadd, self-reported to the Board, but had not been treated for chemical dependence at the time of his reporting. Dr. Sucher said he believed August 3, 2005 to be Dr. Gadd's first relapse. Dr. Sucher said Dr. Gadd had been treated for depression in 1978 and had some self-medicating issues. As a result the physician was monitored by Medical Board for one year with drug testing. Dr. Sucher said he should be treated as someone who has relapsed for the first time, but should not return to practice without appropriate recovery.

Patrick N. Connell, M.D. moved to go into Executive Session at 3:46 p.m.

The Board returned to open session at 4:01 p.m.

Tim B. Hunter, M.D. said that if the physician kept his license he should have in-patient treatment. Dr. Hunter said that even though he attests he would not practice under the license, with an active license the physician may practice medicine at any time and the public's health and safety must be considered by the Board.

MOTION: Patrick N. Connell, M.D. moved to continue the matter and invite the physician for a formal interview in December. The practice restriction remains in place.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9- yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-04-0382A	AMB	PAUL A. AUPPERLE, M.D.	30485	This matter has been moved to Other Business #25

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-03-1280A	T.H.	MARVIN L. GIBBS, M.D.	13736	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for falsifying information on an application for hospital privileges and for failure to maintain adequate records on a patient.

Marvin L. Gibbs, M.D. was present without legal counsel.

Cathy Riggs, Manager of Investigations, presented the case to the Board. On December 9, 2003 the Arizona Medical Board received a report from Tempe St. Luke's Hospital that Dr. Gibbs had been denied reappointment for providing false information on his application when he failed to disclose he was under investigation by the Board for internet prescribing. Reappointment was also denied on the basis of his continual failure to timely complete medical records on patients who were hospitalized. Dr. Gibbs had a fair hearing with the hospital, but failed to convince them of his explanation for the allegations. Dr. Gibbs also lost privileges at other facilities with whom he had failed to provide information about on the application. Ms. Riggs said Dr. Gibbs has a history for incorrectly responding on a hospital application in 1995 for which he received an Advisory Letter from the Board.

Dr. Gibbs, said he did not believe he was in violation of the statutes and denied the allegations brought against him.

Tim B. Hunter, M.D. lead the questioning and asked Dr. Gibbs why he responded incorrectly on the hospital application after becoming aware he was under investigation for internet prescribing by the Arizona Medical Board. Dr. Gibbs said he drafted a letter to be sent with his hospital application stating the details for the investigation, but that his office staff failed to mail the letter with the application in February of 2002 and Dr. Gibbs was unaware the first letter was not mailed until he sent a follow-up letter noting his status to the hospital in September 2002.

Dr. Hunter asked about the twenty-five inadequate medical records for which the hospital suspended his license. Dr. Gibbs stated twelve of the records were incomplete in the month of June, the same month he was preparing to undergo the PACE evaluation, as required by the Board, and therefore did not have time to keep up on his charts. Dr. Gibbs said that ten of the medical records were incomplete because of signatures that were required for reports he had completed. Finally, two of the medical records were incomplete because of discharge summaries.

Robert P. Goldfarb, M.D. asked Board Staff if Dr. Gibbs had known about the Board's investigation at the time when he filled out the hospital application. Christine Cassetta, Board Legal Counsel noted that Dr. Gibbs received a subpoena from the Board regarding the investigation a couple months before he filled out the hospital's application.

Paul M. Petelin, Sr., M.D. asked Dr. Gibbs if he had paid his civil penalty. Dr. Gibbs said he is not been financially able to pay.

MOTION: Tim B. Hunter, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) (t)- Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution (e)- Failing or refusing to maintain adequate records on a patient
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

MOTION: Tim B. Hunter, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for falsifying information on an application for hospital privileges and for failure to maintain adequate records on a patient.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Members were absent: Ronnie R. Cox, Ph.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D.,
VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-04-0013A	AMB	CALVIN A. SCHULER, M.D.	11229	No action was taken.

Calvin A. Schuler, M.D. and his counsel, Steve Meyers, were present.

Tim B. Hunter, M.D. moved that the Board go into Executive Session at 5:35 p.m.
The Board resumed Open Session at 5:42 p.m.

MOTION: Tim B. Hunter, M.D. moved that no action be taken at this time.
SECONDED: William R. Martin, III, M.D.
VOTE: 9 yay, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED

FRIDAY, October 7, 2005

CALL TO ORDER
Tim B. Hunter, M.D., Chair, called the meeting to order at 8:00 a.m.

ROLL CALL
The following Board Members were present: Tim B. Hunter, M.D., M.D., Douglas D. Lee, M.D., Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, William R. Martin, III, M.D., M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D., The following Board Member was not present: Sharon B. Megdal, Ph.D.

CALL TO THE PUBLIC
Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0859A	AMB	ROY R. GETTEL, M.D.	11015	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure and a Five Year Probation for Practice Restriction – physician may not perform open reduction and internal fixation.

Roy R. Gettel, M.D. was present with counsel, Mr. Jack Redhair.

Robert P. Goldfarb, M.D. stated he knows both Dr. Gettel and Mr. Redhair, but it will not affect his ability to adjudicate the case.

Gerald Moczynski, M.D., Medical Consultant, presented the case to the Board. The case was brought to the Board as a result of a settlement of a malpractice case. The patient, who had rheumatoid arthritis, rheumatoid hand deformities and osteoporosis fell on November 19, 2001 and sustained an ankle fracture. Dr. Gettel performed an operation on November 20, 2001, providing both medial and lateral fixation of the fracture. Dr. Gettel discharged the patient from the hospital noting, at various office visits postoperatively, the patient had good alignment and the fracture looked well fixed.

On an X-ray taken on December 21, 2001, Dr. Gettel noted the fracture had slight varus, but he thought it would work out and allowed the patient to begin weight bearing. On June 18, 2001, Dr. Gettel noted the patient had sagged into varus. Dr. Gettel re-operated on the patient on February 1, 2002. During the surgery, Dr. Gettel removed the original plates and screws and an attempt was made to apply a medial plate. These attempts did not seem to correct the fracture, and so Dr. Gettel manipulated the fracture and applied a cast. The postoperative handwritten note stated the fracture was in 22 degrees varus. Dr. Gettel's dictated note documented there was approximately seven degrees varus.

The patient was again seen in March of 2002, because of the varus deformity, Dr. Gettel recommended a distal tibia osteotomy to correct the varus deformity. The patient was later seen by Dr. Ruth, another orthopedic surgeon, because of persistent drainage of the wound and had a debridement of the wound in May of 2002.

The case was reviewed by an Outside Medical Consultant who felt Dr. Gettel fell below the standard of care when he failed to perform an adequate open reduction internal fixation of the fracture and allowed the patient to weight bare on an inadequately fixed ankle fracture.

Dr. Gettel said the fracture was a difficult and unique fracture. He said he tried to do a simple procedure on the patient because rheumatoid arthritis patients do not heal as quickly. Dr. Gettel said the X-rays didn't show any change between the time of the November surgery and the December surgery when the second X-ray was taken. Dr. Gettel said he realized pre-operatively the plafond was in tact but a portion of the plafond had been compressed vertically in a varus direction.

William R. Martin, III, M.D. led the questioning and asked Dr. Gettel why he allowed the patient to bear weight. Dr. Gettel said he believed the patient must weight bear because osteoporosis would take over the patient's body if she did not have continuing stimulation. Dr. Martin noted it was below the standard of care to allow a patient weighing 150 lbs to weight bear on an osteoporitic bone that had two screws. Dr. Gettel said it was more important for a patient with osteoporosis to weight bear than for someone without osteoporosis.

The Board then viewed the X-rays of the patient. Dr. Martin noted the goals of the surgery were not met because the anatomy and alignment of the patient was not restored. Ram R. Krishna, M.D. noted the osteoporitic bones were soft before surgery and it appeared from the X-ray the screws were pressed into the fracture site. Dr. Krishna noted that placing a screw or metal into the fracture site falls below standard of care. Dr. Gettel felt that the screw going across the fracture site was acceptable. Dr. Krishna noted that one screw would not hold the fracture. Dr. Gettel stated that was why he inserted two screws. Dr. Krishna asked why more support was not used to hold the fracture.

Dr. Martin noted the standard of care was not met in that the post-operative notes did not mention the patient's prolonged wound-healing problems that lasted approximately three to four months. Dr. Martin also said the standard of care was not meet in that the surgery was not performed within five hours of the injury.

Paul M. Petelin, M.D. noted it may have been helpful if Dr. Gettel would have sought advice from another surgeon or asked a colleague to assist him with the surgery. Mr. Redhair contended that Dr. Gettel is supported by two other physicians who did not have criticism of the surgery.

Dr. Martin stated the standard of care is clear both in literature and the community and part of the standard of care is to restore the anatomy and the alignment of the patient and that was not met. Dr. Martin said the post-operative treatment was not appropriate and the physician should have protected the patient against weight bearing. Dr. Martin said he believes there are issues regarding the physician's judgment.

Dr. Martin noted this was not the first time physician appeared before the Board in that the physician had received four Advisory Letters and a Letter of Reprimand in the past, many of which related to surgical judgment and fixation.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patrick N. Connell, M.D.

MOTION: William R. Martin, III, M.D. moved to issue Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure and a Five Year Probation restricting the physician from performing open reduction and internal fixation.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D. The following Board Member voted against the Motion: Tim B. Hunter, M.D., Lorraine Mackstaller, M.D., Paul M. Petelin, Sr., M.D. The following Board Members abstained from voting: Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D. The following Board Member was not present: Sharon B. Megdal, Ph.D.
VOTE: 6-yay, 3-nay, 2-abstain 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-03-1019A	M.D.	HELEN WATT, M.D.	22016	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriate treatment of an abdominoplasty wound and treatment of burns and failure to maintain adequate medical records on a patient. One year of probation with the following terms: Dr. Watt must complete a PACE record keeping course within six months and be subjected to random chart review at the end of one year.

Patient A.T. spoke in favor of Dr. Watt during the Call to the Public. The patient said she received amazing results while under Dr. Watt's care that ten previous physicians had been unable to provide. The patient stated that Dr. Watt always took notes in her medical record each time the patient visited. A.T. also said there are many benefits of the TDP Mineral Infrared Lamp that Dr. Watt uses for healing. A.T. said society needs more doctors like Dr. Watt that think outside "the box".

Helen Watt, M.D. was present and was represented by legal counsel, Mr. Joseph Giovano.

William Wolf, M.D., Medical Consultant presented this case to the Board. This case was a result of a complaint alleging Dr. Watt refused to provide medical records for a patient. During the course of the investigation, it was determined Dr. Watt treated an abdominal incision with TDP Lamp that burned the patient and that Dr. Watt's medical records of the patient were inadequate. The Outside Medical Consultant concluded Dr. Watt's medical records were insufficient to assist in coordinating care by lack of pertinent information and failure to document care on more than one occasion. The Outside Medical Consultant also concluded the lamp therapy placed the fresh abdominal wound at increased risk and further damaged the skin. The consultant stated Dr. Watt applied a possibly contaminating substance to the burn, and that the intact blister should not have been ruptured by Dr. Watt. The Consultant also said there was inadequate follow up of the patient. The Consultant stated additional deviations from the standard of care included lack of supervision of the office secretary relating to the medical records request, the use of back

rooms of Dr. Watt's residence as an office and inappropriate diagnosis codes given the reasons for the patient's visits. Mitigating factors observed were that the patient was not compliant with many aspects of the care and Dr. Watt's mother was very ill during the time of this patient's treatment.

Dona Pardo, R.N., Ph.D. led the questioning and asked about Dr. Watt's training and what her practice is currently geared toward. Dr. Watt said she is Board Certified in Otolaryngology and facial plastic surgery. She holds a Master's Degree in nutrition and her practice is comprised mainly of nutritional medicine. Dr. Pardo noted Dr. Watt made notes on the same page the patients fill out, making it difficult to decipher which notes are the patient's and Dr. Watt's if another physician were to request the records.

Dr. Pardo noted there were no medical records for the patient's visit prior to the surgery or following the surgery. Dr. Watt said when things are busy in the office it is not uncommon for her to document key words during the visit, and fill in the details later that evening. Dr. Watt also noted her mother was seriously ill during this time and she was distracted and occupied with her mother's condition. Dr. Watt said she did not obtain a consent form for the use of the TDP Lamp as the procedure was routine wound care in her office and it did not occur to her a consent form would be necessary. Dr. Watt said she wrote notes of the patient's visit on January 4, 2004 when she realized notes were not in the chart.

Dr. Pardo noted the patient had been under the care of a plastic surgeon during the time Dr. Watt saw the patient and asked why she had interfered with the care of another physician. Dr. Watt said the patient and plastic surgeon had noticed the abdomen wound was not healing appropriately and the patient told Dr. Watt she had some tension with the physician and was not going back. Dr. Watt said it was a difficult time for her personally to see the patient because of the stress of her mother's health, and in retrospect she would have told the patient it was not a good time to see her and she needs to return for follow up with the physician she started with.

Dr. Pardo asked Dr. Watt to explain the office visit with the patient, following the plastic surgeon's procedure. Dr. Watt said she saw the patient after the surgery and treated the patient with the TDP Lamp. The patient called Dr. Watt the next day complaining of a blister. Dr. Watt said she drained the serum from the blister, and told the patient to tap on some anti-bacterial cream and to return the next day, but the patient did not return. She said the reason she drained the blister was so the bacteria could not multiply if the area was infected. Dr. Watt said she believed the patient had a blister and not a burn, and that it was a result of the TDP Lamp's process of delineating and accelerating a deteriorating of tissue that's already non-viable. Dr. Pardo stated that, in the hospital medical records, two physicians diagnosed the occurrence as a burn.

Dr. Pardo also inquired about the allegation that Dr. Watt used her residence as an office. Dr. Watt said she now has a medical office and has not seen patients in her home since December of 2003.

Dr. Pardo asked why Dr. Watt asked the patient not to tell the plastic surgeon she had seen the patient and why Dr. Watt did not call the plastic surgeon to relay the treatment she was giving to the patient. Dr. Watt said she did not communicate with the plastic surgeon because she did not want to cause further friction between the physician and the patient.

Robert P. Goldfarb, M.D. noted Dr. Watt purchased a used TDP lamp and does not have a regular maintenance program to make sure the output is to standard. Dr. Watt said her experience has been that the lamps become less powerful as they get older.

Robert P. Goldfarb, M.D. noted his concern that Dr. Watt did not have the capability to handle a situation if a complication with her treatment occurred since she did not have hospital privileges. Dr. Goldfarb also expressed his concern with the inadequate medical records and the fact the plastic surgeon was not informed Dr. Watt was also treating the patient.

Paul M. Petelin, M.D. asked Dr. Watt to explain the substance used on her patient's wounds. Dr. Watt said the substance is Colostrum - a milk substance that is Bovine derived and is anti-bacterial. Dr. Watt said the substance is usually ingested by the patient, but at times is applied to the skin. Dr. Watt said the substance is never applied on an open wound.

Ram R. Krishna, M.D. asked Dr. Watt asked about current patient operations she had performed. Dr. Watt said the last time she operated was about one month previously, and that she only does minor procedures with local anesthesia in the mini surgical suite in her office.

Tim B. Hunter, M.D. asked the wattage of the TDP Lamp. Dr. Watt said the lamp was about 250 watts and that she doubted it could burn a patient because it is not held close to the skin.

In Dr. Watt's closing statement she said she graduated in the upper 3rd in her class in medical school and has her Master's Degree in Nutrition. She said her treatment of the patient supported the plastic surgeon's work and would have enhanced any subsequent surgeries if the patient chose to go back. Dr. Watt said she did encourage the patient to go back to the plastic surgeon.

Dr. Watt said medical record keeping used to be her forte, but she was concerned of how to word the medical records in a way that would protect the plastic surgeon and therefore did not fill out the records immediately following the visit. Dr. Watt said another reason the medical records were not filled out was because she was focusing on calming and listening to the patient during the visit and would have had time to fill in the details after the patient left the office if she would not have been occupied with her own mother's illness.

Counsel for Dr. Watt, Mr. Giovano, stated Dr. Martin Johnson, plastic surgeon, said there were poor wound healing problems early in the recovery as also noted by the plastic surgeon in his medical record. Dr. Henry Johnson, also indicated the TDP lamp would not have caused a burn in this patient's case, and it's actually used to enhance and facilitate wound healing. Dr. Lam, pathologist, examined the patient's abdomen and stated the only reason he used the term "burn" is because that was what was affixed to the specimen. His findings did not rule in burn, but his findings were consistent with ischemic injury. Mr. Giovano attested the Outside Medical Consultant for the Board did not educate himself about the TDP lamp, from what the Consultant's report indicates, and the same is true regarding the Colostrum. Mr. Giovano commented on sections of the 2005 Liposuction Atlas that speaks of using hydrotherapy of whirlpool baths and heat on the seventh post-op day to increase circulation and reduce edema, which is what the TDP Lamp does. He said the journal also states that garments placed over the wound and over the surgical site must be periodically loosened to avoid girdle necrosis burn. Mr. Giovano stated the evidence does not prove the injury was a burn from the lamp and it was most likely an ischemic injury.

MOTION: Dona Pardo, R.N., Ph.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401 (27) - (e)- Failing or refusing to maintain adequate records on a patient and (ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Dona Pardo, R.N., Ph.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriate treatment of an abdominoplasty wound and treatment of burns and failure to maintain adequate medical records on a patient. One year of probation with the following terms: Dr. Watt must complete a PACE record keeping course within six months and be subjected to random chart review at the end of one year.
SECONDED: Becky Jordan
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D. The following Board Member was not present: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0609A	R.B.	H. ROYER COLLINS, M.D.	16036	Dismissed.

H. Royer Collins, M.D. was present with counsel, Mr. Bryan Murphy.

William R. Martin, III, M.D. and Paul M. Petelin, M.D. said they knew Dr. Collins, but it would not affect their ability to adjudicate the case.

Gerald Moczynski, M.D. presented the case to the Board. The complaint was received from a 71-year-old patient with a prior total hip arthroplasty. In the complaint, it was stated Dr. Collins had misinformed him about the surgical procedure performed, failed to provide a video cassette of the procedure, negligently performed a hip arthroscopy resulting in increased pain, failed to treat his post-op urinary retention and failed to order physical therapy in a timely manner. An outside medical consultant reviewed this chart and concluded the patient was not adequately informed about the procedure, and should have been offered another procedure other than a hip arthroscopy. However, the consultant felt the hip arthroscopy was appropriately performed, and that Dr. Collins had treated the post-op urinary retention appropriately and did arrange physical therapy in a timely manner.

Dr. Collins said the patient insisted his hip pain was different than the hip on the other side that required a total hip replacement because there was a catching and locking sensation in his hip. Dr. Collins said he discovered during the procedure that the patient had a torn labrum. He also discovered the patient had a more extensive degenerative change in his hip than was shown on the X-rays. The patient stated the hip was feeling better following the procedure, but he began to have arthritic pain with physical therapy. Dr. Collins advised the patient discontinue physical therapy, take an anti-inflammatory medication, and return in one month. However, the patient never returned to see Dr. Collins.

Ram R. Krishna, M.D. led the questioning. Dr. Collins stated most of his hip arthroplasties are done on an athletic population. The patient in this case was the oldest patient he had performed the procedure on. Dr. Collins said the patient came to him wanting an alternative to a total hip replacement. Dr. Collins said he did not contact the patient's PCP and could not verify he had seen the patient's magnetic resonance imaging report (MRI), but that he could verify he had read the report. Dr. Collins said the MRI report would most likely have not shown a tear.

Mr. Murphy stated there was discussion with the patient and informed consent before the procedure. Mr. Murphy said he had expert reports and training materials to refute the "sham surgery" claim. Mr. Murphy stated this was a conservative step to address a problem that, if the procedure was unsuccessful, would lead to major surgery. Mr. Murphy concluded by saying the physician has been licensed in seven states for a period of over 40 years and this is his first Board complaint in any state.

Dr. Moczynski stated he felt there were mitigating factors in this case.

Dr. Krishna stated the patient sought the physician's care, and after speaking with the physician he realizes he has the knowledge necessary for handling this case. Dr. Krishna also noted Dr. Collins said that, in retrospect, since the MRI was not clear he may have done an arthrogram. Dr. Krishna stated he did not believe the case was handled inappropriately or that the outcome was unfortunate.

MOTION: Ram R. Krishna, M.D. moved to Dismiss the case.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Member was not present: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-04-0977A	B.P.	CRAIG ALAN BITTNER, M.D.	27982	Draft Findings of Fact, Conclusions of Law and Order for Probation for one year requiring restitution to the complainant in the amount of $3,810. Probation may end upon proof of restitution.

Craig A. Bittner, M.D. was present without legal counsel.

Patricia McSorley, Senior Medical Investigator presented the case to the Board. On August 2, 2004 the Board received a complaint that B.P. had paid $3,810 to Dr. Bittner for MRI imaging services in 2003. Thereafter an appointment was scheduled to take place in one of Dr. Bittner's clinics in San Francisco. That appointment was cancelled because the San Francisco clinic closed. A second appointment was scheduled for B.P. to have his scan done at San Jose California. The San Jose location closed a week before the scheduled appointment. B.P. contacted Dr. Bittner several times to obtain a refund for the services he never received. Dr. Bittner was the founder of Ameriscan and its CEO. To date, B.P. has not received a refund.

Dr. Bittner read a letter from an employee who was formerly in the group whose job was to scheduling and servicing patients. Dr. Bittner stated they attempted to contact each patient when they knew the company was closing to encourage them to use their credit immediately.

Ronnie R. Cox, Ph.D. led the questioning. Dr. Cox asked Dr. Bittner if Dr. Bittner had a current affiliation with the company. Dr. Bittner said the company was dissolved by the Arizona Secretary of State. Dr. Bittner stated he was the sole owner of the medical group and not of the centers.

Dr. Cox, noted the patient's payment is still an outstanding debt for the company.

Patrick N. Connell, M.D. asked Dr. Bittner what percentage of Ameriscan he owned. Dr. Bittner stated he owned the company completely. Paul M. Petelin, M.D. asked if Dr. Bittner was aware of any other patients who needed a refund. Dr. Bittner stated this is the only patient he knows of that has made this complaint and that he kept a website open for eight months after he closed the center in order to make due effort.

Douglas D. Lee, M.D. asked if the other lawsuits the company was involved in were related to this patient's complaint. Dr. Bittner said they were not related.

Robert P. Goldfarb, M.D. moved to go into Executive Session at 12:15 p.m.
The Board resumed Open Session at 12:27 p.m.

Dr. Petelin asked Dr. Bittner if he felt any ethical or professional obligation to refund the patient's money. Dr. Bittner stated he did not know if he had an obligation to pay the patient, but would have been willing to provide services if the centers were still open.

MOTION: Ronnie R. Cox, Ph.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (u)-Charging a fee for services not rendered or dividing a professional fee for patient referrals among health care providers or health care institutions or between these providers and institutions or a contractual arrangement that has the same effect.
SECONDED: William R. Martin, III, M.D.

MOTION: Ronnie R. Cox, Ph.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a one year, or upon proof of payment, Probation with restitution to the complainant in the amount of $3,810.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D. The following Board Member was not present: Sharon B. Megdal, Ph.D.

	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-04-0031A	AMB	BERTRAND P. KAPER, M.D.	27483	Dismissed

Bertrand P. Kaper, M.D. was present with counsel, Mr. Andrew Rosenzweig.

Gerald Moczynski,M.D., Medical Consultant, presented the case to the Board. The case came to the Board as the result of a settlement of malpractice case. The patient was seen in Emergency Room with a fracture and was discharged with dressing and a knee mobilizer. Dr. Kaper evaluated the patient the next day when the patient's friend said she was having trouble moving around. Dr. Kaper readmitted the patient to the hospital. The patient did not return to Dr. Kaper's office for follow up, but rather followed up with her primary care physician. The patient was subsequently referred to Dr. Miller and had a total knee arthroplasty. The Outside Medical Consultant felt Dr. Kaper failed to diagnose the patient's unstable tibia plateau fracture and perform corrective surgery in a timely manner.

Ram R. Krishna, M.D. led the questioning. Dr. Kaper said the patient was anxious to leave the hospital and he discharged the patient by making a phone call from his office. Dr. Kaper said he did not try to reach the patient, but this was his first case when the patient did not follow up with him after being at the hospital.

Dr. Krishna asked Dr. Kaper if he had intended to do a computed tomography (CT) scan on the patient. The physician said he could not recall and did acknowledge his chart documentation could have been better. Dr. Kaper stated that knowing what he knows now, he would have done the CT scan.

Tim B. Hunter, M.D. commented he felt the patient missed the first window of surgical opportunity. Dr. Kaper said he did not understand the seriousness of the injury when he learned of it over the phone, but now he drives to the hospital and reads every X-ray he is consulted about.

Patrick N. Connell, M.D. noted at the time of her discharge, the patient had not been accepted on ACCHHS and asked Dr. Kaper if that may have been a reason the patient did not follow up with him. Dr. Kaper said he does not turn away patients because of a lack of insurance. Dr. Connell asked if Dr. Kaper felt under pressure from the hospital not to operate acutely on the patient because the patient was self-paid. Dr. Kaper said the hospital gave him no pressure and the lack of insurance was not a factor in the decision making process.

Dr. Connell noted the nurse wrote on the hospital discharge sheet that the patient needed to follow up with the primary care physician. Dr. Kaper said recollects he told the nurse, over the phone, to have the patient follow up with him within five to seven days.

Dr. Kaper, summarized the case by commenting on how much displacement the patient's fracture had. Although the MRI done six weeks after the fact showed a centimeter of depression, Dr. Kaper didn't believe there was a centimeter at the initial presentation, and feels orthopedic literature supports a percentage of variability in which both radiologist and orthopedic surgeons read the measurements on X-rays.

Mr. Rosenzweig stated the primary care physician never referred the patient back to Dr. Kaper and in fact altered his records to say he had referred the patient to an Orthopedic Surgeon, when in the physician's initial set of medical records, the referral was not mentioned.

Dr. Krishna stated there were mitigating factors in this case, primarily the patient did not see Dr. Kaper in follow up and the primary care physician did not refer the patient back to the Orthopedic surgeon. Dr. Krishna stated he believes Dr. Kaper's knowledge of the fracture is correct and that he would have conducted the appropriate follow up if he would have seen the patient back in his office.

MOTION: Ram R. Krishna, M.D. moved to Dismiss the case.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D.
The following Board Member was not present: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-04-0974A	M.R.	ROBERT H. WOODS, M.D.	22242	Dismissed

Robert H. Woods, M.D. was present and represented by legal counsel, Mr. Cal Raup.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. An Outside Medical Consultant reviewed the case. The complainant alleged Dr. Woods had not thoroughly informed her about her sinus problem, had operated on her unnecessarily, and the patient criticized his recordkeeping and his billing. The Outside Medical Consultant felt the only supported allegation was the medical record keeping because the findings were not well recorded. Dr. Huber noted Dr. Woods has received previous Board action in reference to his medical record keeping.

Dr. Woods opened by stating he does not refute his inadequate medical records for this case. Dr. Woods said when he was placed on Probation in 2002 he immediately tried to take corrective action, but because he was trouble shooting on developing a better record keeping system, his records became worse before getting better. Dr. Woods said that since taking the Physician Assessment and Clinical Evaluation (PACE) program he now has a voice activated system for recording medical records. Dr. Woods stated the patient in this case was seen prior to his improvement of his medical record keeping.

Ram R. Krishna, M.D. led the questioning and asked Dr. Woods about the various decisions he made regarding the patient's care. Dr. Woods answered all of the questions satisfactorily.

Dr. Krishna stated it was clear to him the standard of care was met. The only question he had was regarding documentation, and the case happened just before the physician finished the PACE evaluation, and there has been improvement since that time.

MOTION: Ram R. Krishna, M.D. moved to dismiss the case.
SECONDED: Becky Jordan
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D. Paul M. Petelin, Sr., M.D. The following Board Member was not present: Sharon B. Megdal, Ph.D.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-04-0739A	AMB	SCOTT WASSERMAN, M.D.	23328	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for falsely advertising an employee as a licensed physician and/or an aesthetician. One year of probation with 10 hours CME in ethics. Probation to terminate upon completion of CME.

Scott Wasserman was present with counsel, Mr. Cal Raup.

Victoria Kamm, Senior Medical Investigator, presented the case to the Board. Board Staff received information that Dr. Wasserman may have employed an unlicensed doctor of medicine. It was alleged that Dr. Wasserman employed Veronique Sananes, who is identified as a doctor in an advertisement appearing in a June 2004 magazine. However, Ms. Sananes is not licensed to practice medicine in the State of Arizona, nor is she licensed by the Arizona cosmetology board. An investigation was opened based upon the allegation that an illegal practitioner is or may be providing medical services in Dr. Wasserman's office.

Becky Jordan led the questioning. She asked Dr. Wasserman about the advertisement on website. Dr. Wasserman stated Ms. Sananes was listed as an M.D. on his website because it was his understanding that since she earned the degree, she was entitled to use that designation after her name. Dr. Wasserman stated he no longer employs Ms. Sananes. Dr. Wasserman verified that Ms. Sananes was the only unlicensed provider that he has had.

Tim B. Hunter, M.D. asked Christine Cassetta, Board Legal Counsel if a person had an M.D. degree, but was not licensed in the state, if they could use the M.D. designation after their name. Ms. Cassetta advised that in personal correspondence to an acquaintance, the M.D. designation would be okay, but use of the designation M.D. in a way that would lead the public to believe that a person was licensed to practice medicine in this state is a criminal violation.

Dr. Wasserman said he was not aware that the M.D. designation could not be used after a name if the person had the degree and that he in no way meant to advertise that Ms. Sananes was serving as a physician in his office.

Lorraine Mackstaller, M.D. asked that if when Ms. Sananes performed procedures that Dr. Wasserman did, if Dr. Wasserman billed patients as if Ms. Sananes were an M.D. Dr. Wasserman said his employees are paid a portion of the fee on an individual basis, but the cost of the procedure is a flat fee.

Paul M. Petelin, Sr., M.D. asked how Ms. Sananes was addressed in his office. Dr. Wasserman stated his office staff and patients addressed her by her first name and that the patients were told she was not employed as a medical doctor. Dr. Wasserman said he did not allow Ms. Sananes to see patients independently, and that he limited her scope of practice.

William R. Martin, III, M.D. asked if the procedures performed by Ms. Sananes were ones that required no experience as a doctor. Dr. Wasserman stated he has been unable to get a clear answer regarding what type of work can be done by someone who is under a physician's supervision.

Douglas D. Lee, M.D. asked Dr. Wasserman if he felt an aesthetician should be licensed. Dr. Wasserman said he was told by Ms. Sananes that she filed her paperwork with the Arizona Board of Cosmetology and he believed her license was about to be issued.

Ms. Jordan also asks asked if Dr. Wasserman performed liposuction. Dr. Wasserman said he is the only one that does that procedure in his office.

Robert P. Goldfarb, M.D. asked if there were any other marketing tools that listed Ms. Sananes as an M.D. Dr. Wasserman stated he was only aware of the article published and the website.

Dr. Petelin asked about the biography of Ms. Sananes and where it was posted. Dr. Wasserman stated he did not know how extensively the biography was sent out.

In closing, Dr. Wasserman said admits he could have been more thorough in keeping Ms. Sananes' identity and although he takes responsibility for the misleading it was not his intention. He stated he takes the Board's positions very seriously.

MOTION: Becky Jordan moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (a)- Violating any federal or state laws or rules and regulations applicable to the practice of medicine, (c)- False, fraudulent, deceptive or misleading advertising by a doctor of medicine or the doctor's staff, employer or representative and A.R.S. 32-574 (a)5 Which is the Cosmetology board statute, stating a person shall not permit an employee or another person under the person's supervision or control to perform among other things, aesthetics without a license.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Becky Jordan moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for falsely advertising an employee as a licensed physician and/or an aesthetician. One year of probation with 10 hours CME in ethics. Probation to terminate upon completion of CME.
SECONDED: Ram R. Krishna, M.D.

Dr. Hunter said he feels the situation does not rise above an Advisory Letter because the physician has been forthright and has corrected the problems in his practice.

Dr. Krishna stated his view that Dr. Wasserman knew Ms. Sananes was person was did not have an Arizona License and yet was billing for her services. Dr. Cox spoke in support of the motion because he said there was gain by physician as stated by Dr. Krishna.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Tim B. Hunter, M.D., Patrick N. Connell, M.D., Dona Pardo, R.N., Ph.D The following Board Member was not present: Sharon B. Megdal, Ph.D.
VOTE: 8-yay, 3-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-04-0018A	C.S.	DAVID PARRISH, M.D.	26896	Letter of Reprimand for misdiagnosis and mismanagement of thyroid disease and Probation, including a Six-month Suspension. The Suspension will remain in effect until which time the PACE results are evaluated by the Board.

Patient R.S. was present and spoke on Dr. Parrish's defense. The patient said he has suffered from complex problems including depression and migraines since 1978. Dr. Parrish's approach is different in that focused on the whole body and mind. R.S. said Dr. Parrish has always presented evidence about his suggestions for the patient's care and would call colleague if he felt he was out of his field of expertise. R.S. stated

Dr. Parrish suspected something had been missed on the patient's yearly magnetic resonance imaging report (MRI), and did a different scan and discovered the patient had a brain tumor. R.S. stated Dr. Parrish saved his life and that after having seen hundreds of doctors who were unable to help him, Dr. Parrish was able to appropriately diagnose his condition. The patient concluded by saying it would be a disservice to the physician and the community to censure the doctor in anyway.

David Parrish, M.D. was present but was not represented by counsel.

Kelley Sems, M.D., Medical Consultant presented the case to the Board. She stated she knows of Dr. Parrish from her time practicing in another state, but that it will not affect her ability to present the case to the Board.

An allegation was brought against Dr. Parrish that he misdiagnosed adrenal insufficiency and mismanaged medical care for a patient. An Interim Order for evaluation was executed on February 16, 2005 instructing Dr. Parrish to submit to a PACE evaluation within 90 days. Dr. Parrish failed to present for the PACE evaluation.

Dr. Parrish stated he regrets he misunderstood the Board's Order. Dr. Parrish said he believed he was still under investigation by the Board and was advised by his legal counsel the Order was stayed until the final adjudication of his competence was made. Dr. Parrish stated the mistake was unintentional; he did not question the Board's authority, but was advised the evaluation cost would cost $18,000 and wanted to make sure the Order was in effect before he had the evaluation. He stated he has since been advised by new counsel that he should have filed a motion for rehearing.

Patrick N. Connell, M.D. verified that the Board Staff reminded Dr. Parrish on several occasion to complete the evaluation by the deadline.

Dr. Connell stated the Board determined at a previous meeting that there was unprofessional conduct in regard to the treatment of the thyroid disease. He also stated that, during the course of the interview, there was significant concern about the doctor's competence.

MOTION: Patrick N. Connell, M.D. moved to issue a Letter of Reprimand for misdiagnosis and mismanagement of thyroid disease, and Probation which would include Suspension that remains in effect until which time the PACE results are evaluated by the Board, but not more than one year.
SECONDED: Ronnie R. Cox, Ph.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, Sr., M.D. The following Board Member was not present: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

The Board recessed for an Emergency Summary Action Meeting at 4:40 p.m. and returned to the regularly scheduled meeting at 5:53 p.m.

The Meeting was adjourned at 6:30 p.m.

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Timothy C. Miller, J.D., Executive Director